Patient Information

Patient Name: _____ Date: _____

Gender: _____ Marital Status:_____ Social Security #: _____

Birth Date: _____ Age_____Email:_____

Phone (Home): _____ (Work): _____ (Cell): _____

Best time to call: _____ Preferred appointment times: ☐ Morning ☐ Afternoon

Address: _____

_____

General Dentist: _____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Health Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatic Disorder
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Do You Smoke?___

OTHER

☐ _____

- Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever taken Bisphosphonate medication for osteoporosis/penia? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Please list all medications you are currently taking _____

_____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Internet ☐ Work ☐ Other _____
Name of person or office referring you to our practice: _____

Employment Information

Employer Name: _____ Occupation: _____
Address: _____
Phone:_____

Dental Insurance Information

Fill In Below If You Need Assistance In Filing So You May Be Directly Reimbursed By Insurance

Primary
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____

Insured's Employer Name and Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company Name and Address:_____

Secondary
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name and Address:: _____

Insurance Company Name and Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with all claims.

Signature _____ Date _____

Payment Is Due In Full At The Time Of Your Visit

As a condition of your treatment by this office, financial arrangements must be made at time of service**. While we do not participate with any insurance company, we will gladly file with your insurance company for surgical procedures and include all documentation needed so that you may be reimbursed from your insurance company**. **The full fee is due at the time of service.** Filing with your insurance is not a guarantee of payment.

I understand the above information is necessary to provide me with excellent dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider that may release such information to you. I will notify my dentist of any changes in my health or medication.

I grant my permission to you or your assignee to contact me to discuss matters related to this form.

Lastly, I understand that all responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time of service. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian