Patient Information

Patient Name: ________________________________ ____________ Date__/__/____

Last, First M (name you prefer)

Gender: ________ Family Status: ____________

Social Security #: ______________________________ Birth Date:___________

Phone (Home): ____________ (Work): ____________ Ext: ______ (Cell Phone): ____________

Address: ____

Street Apartment #

____

City State Zip Code **E-mail address**

Employment Information

Employer Name: __________________________________ Occupation: ________________

Address: ____

Health Information: **Name of person referring you to us?**______________________

Have you ever been told that you need to pre-medicate for your dental visits?______________________________

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

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur/ MVP
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ **Pregnancy-current** Due date:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

☐ ________________

MEDICATIONS

____

____

Are you on Bisphosphonates?
ie. Fosamax, Boniva, Actonel, Aredia, Didronel, Reclast, Skelid or Zometa?

- Have you ever been told you have periodontal disease? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ 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: ____

To the best of my knowledge, all of 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

I authorize my insurance company to release payment for my dental visits to this office.

____

Signature

I authorize the release of my information for billing, financial and referral purposes as needed by this office.

____

Signature

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ____________

Name of person or office referring you to our practice: ______________________________________

Spouse or Responsible Party Information

The following is for the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________

Social Security #: ______________________________ Birth Date: _________________________

Phone (Home): _______________ (Work): _______________ Ext: ______ cell phone: __________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: _________________________

Address: ____

Street City, State Zip Code Phone

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a **courtesy** to you we will help you process all your insurance claims. **Payment is due at the time service is provided.** Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Outside financing is available through Care Credit, upon request and approval. We do not provide payment plans through our office.

Returned checks have a fee of $30.00, and balances older than 60 days may be subject to collection fees and service charges.

Additionally, our office will charge you $30.00 for broken appointments and appointments cancelled without 24-hour advance notice. **We reserve special time for each patient. If we are not given notice, we are unable to fill this space with other patient appointments and our overhead costs rise.**

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

______________________________ ________________________

Signature Date