Patient Information (CONFIDENTIAL)

Patient # ____________
SS#/SIN ____________
Date ____________

Name ____________ Birthdate ____________ Home Phone ____________

Mailing Address ____________ City ____________ State/Prov. ____________ Zip P.C. ____________

Email ____________ Cell Phone ____________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College ____________ City ____________ State/Prov. ____________ ☐ Full Time ☐ Part Time

Patient's or Parent/Guardian's Employer ____________ Work Phone ____________

Business Address ____________ City ____________ State/Prov. ____________ Zip P.C. ____________

Spouse or Parent/Guardian's Name ____________ Employer ____________ Work Phone ____________

Whom May We Thank for Referring You? ____________

Person to Contact in Case of Emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________

Address ____________

Home Phone ____________ Cell Phone ____________

Driver's License # ____________ Birthdate ____________ Financial Institution ____________

Employer ____________ Work Phone ____________ SS#/SIN ____________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard

Insurance Information

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ SS#/SIN ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Address of Employer ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________

Insurance Company ____________ Group # ____________ Policy/ID # ____________

Ins. Co. Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________

How Much is your Deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ SS#SIN ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Address of Employer ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________

Insurance Company ____________ Group # ____________ Policy/ID # ____________

Ins. Co. Address ____________ City ____________ State/Prov. ____________ Zip/P.C. ____________

How Much is your Deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____________

Signature of patient (or parent/guardian if minor)

HIPAA Acknowledgement

I have reviewed and understand the HIPAA privacy policy of this office

X ____________

Medical History

Have you ever had any of the following medical conditions or problems? Please circle.

1. CARDIOVASCULAR

Heart disease or attack	Y N
Angina pectoris or chest pain	Y N
High blood pressure	Y N
Mitral valve prolapse	Y N
Congenital heart defect or lesion	Y N
Artificial heart valve	Y N
Arrhythmia / palpitations	Y N
Heart pacemaker	Y N
Heart surgery or transplant	Y N
Other heart problems	Y N
Stroke	Y N
Aneurysm	Y N

2. HEMATOLOGIC

Blood transfusion	Y N
Anemia	Y N
Hemophilia	Y N
Leukemia	Y N
Sickle cell (anemia) disease	Y N
Tendency to bleed longer than normal	Y N

3. NEURAL AND SENSORY

Glaucoma	Y N
Earaches, ringing in ears	Y N
Psychiatric treatment	Y N
Severe headaches	Y N
Fainting and dizzy spells	Y N
Epilepsy, seizure or convulsions	Y N
Downs Syndrome	Y N

4. GASTROINTESTINAL

Stomach / Intestinal ulcers	Y N
Colitis	Y N
Eating disorder	Y N
Hepatitis	Y N
Yellow jaundice	Y N
Cirrhosis	Y N
Liver Transplant	Y N

5. RESPIRATORY

Sinus trouble	Y N
Allergies or hives	Y N
Asthma	Y N
Breathing difficulties	Y N
Emphysema	Y N
Chronic cough	Y N
Positive Tuberculin Skin Test	Y N
Tuberculosis	Y N
Bronchitis	Y N
Mouth breathing	Y N

6. DERMAL MUCOCUTANEOUS MUSCULOSKELETAL

Allergy to latex (rubber)	Y N
Skin Rash	Y N
Night sweats	Y N
Dark mole(s) (recent changes in appearance)	Y N
Stiff joints / arthritis	Y N
Artificial joint	Y N
Fever blister, cold sore, herpes	Y N
Mouth ulcers or canker sores	Y N
Colored or discolored areas in mouth	Y N
Other allergies (food, etc.)	Y N

7. ENDOCRINE

Diabetes	Y N
Dialysis / transplant	Y N
Insulin dependent	Y N
Thyroid disease	Y N

8. HAVE YOU HAD:

Hospitalization	Y N
Surgery	Y N
Accidents	Y N

9. OTHER CONDITIONS

Frequent sore throat	Y N
Recent eye surgery	Y N
Enlarged lymph node or gland	Y N
Use tobacco	Y N
Use alcohol	Y N
Drug or alcohol addiction (recovering or current)	Y N
Tumor or cancer	Y N
Radiation therapy	Y N
Chemotherapy	Y N
HIV positive (AIDS)	Y N
Pregnancy	Y N
Due Date____________	
Take Antibiotic prior to dental appointments	Y N
Disease, problem or condition not listed	Y N
If yes, list____________	

10. HAVE YOU HAD AN ALLERGIC REACTION TO A MEDICATION, SUCH AS:

Erythromycin	Y N
Aspirin	Y N
Codeine	Y N
Penicillin	Y N
Sulfa drugs	Y N
General anesthetic	Y N
Dental anesthetic	Y N
Barbituates	Y N
Other	

If so, please name__________________

11. ARE YOU:

Under the care of a physician	Y N
Taking medications now or within the past year, such as:	
Blood thinners	Y N
Cortisone	Y N
Tranquilizers	Y N
Nitroglycerine	Y N
Penicillin	Y N
Aspirin / Ibuprofen	Y N
Digitalis, heart medication	Y N
Blood pressure medication	Y N
Birth control pills	Y N
Pain Medicine	Y N
Alka Seltzer	Y N

COMMENTS TO EXPLAIN YES ANSWERS OR LIST MEDICATIONS:

____

____

____

____

Office Policy

Our office is committed to providing you with the best dental health care. To achieve this goal, we appreciate your cooperation as well as your understanding of our office policy.

You the patient are responsible for payment as services are rendered.

For patients who prefer to make monthly payments we accept VISA / MASTERCARD.

For patients with dental insurance you will be responsible for your estimated co payment at the time services are rendered. We are happy to research your dental insurance plan. We will file the necessary forms to see that you receive full benefits, however we make no guarantee of your estimated insurance coverage. Please know that we will do everything possible to see that you receive full benefits.

As a courtesy to our patients we confirm appointments one to two days prior to your scheduled appointment time. We require 24 hours notice for any necessary change of your scheduled appointment time. Failed or cancelled appointments without 24 hour notice will be charged a broken appointment fee of $25 per every 1/2 hour of scheduled time.

Our goal with each of our patients is to help them enjoy the benefits of good dental health. Thank you for choosing us to provide your care.

I have read and understand the above information.

*Signature*____________________________________