

PATIENT INFORMATION



First Name: _____ MI: _____ Last: _____ Nick Name: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 DOB: _____ Male Female Single Married SS#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Employer: _____
 E-mail Address: _____
 Name of Physician: _____ Physician Phone: _____
 In case of Emergency Contact: _____ Relationship: _____ Phone: _____
 How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Type(s) _____	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hip or Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

Medical Questions

List any medications you are taking including nonprescription drugs: _____

 Do you have any disease/problem you think we should know about? YES No

 Are you allergic to any medications? YES No If yes, please list below:

 Are you in good health? YES No
 Date of last medical exam: _____
 Have you ever been hospitalized? YES No If yes, what was the problem

 Have you had a transplant operation that has depressed your immune system?
 YES No
 Have you had an allergic reaction to Bananas? YES No
 Do you smoke or chew tobacco? YES No
 Have you had Heart Surgery? YES No
 Are you now under the care of an MD? YES No
 Are you taking or have you ever taken bisphosphonates?
 (Fosamax or Actonel for osteoporosis, chemotherapy, etc...) YES No

FOR WOMEN ONLY:

Are you taking birth control pills? YES No
 Are you nursing/breastfeeding? YES No
 Are you pregnant? YES No Expected delivery date: _____
 Is there a possibility of pregnancy? YES No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Dental History Information

Date of last dental visit? _____

Do you have problems with bad breath? YES No

Name of your previous dentist _____

Have you ever had an allergic reactions to a crown, metal filling or

Reason for today's visit? _____

dental appliance? YES No

Have you ever had an oral cancer screening? YES No

Have you ever used an electric toothbrush? YES No

How often do you floss your teeth? _____

Are your teeth sensitive to hot, cold or pressure? YES No

Do your gums bleed when you brush? YES No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Have you or a family member ever been treated for periodontal disease?

YES No

If you could change something about your smile what would it be:

Have you ever had complications from an extraction? YES No

Whiter

Have you ever had a popping or clicking near your ear when you chew?

YES No

Straighter

Are you prone to frequent headaches? YES No

Close space

Do you grind or clench your teeth? YES No

replace black mercury filling with tooth colored restorations

Do you have sores, blisters or swelling on your gums lips or cheeks?

YES No

repair chipped teeth

Have you ever had orthodontic treatment? YES No

replace missing teeth

Do you snore? YES No

less gums showing

replace old crowns or caps that don't match

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____



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PAYMENT ARRANGEMENT FORM

NAME OF PATIENT: _____ ("patient")

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me.

I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a finance charge equal to 12% APR if my balance goes beyond 90 days past due; 2) an amount equal to \$35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee of \$50.00 for each appointment that is missed/canceled without at least 48 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to a collection agency that a fee of 30% of my current balance will be applied. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

RESPONSIBLE PARTY:

Full Name: _____ DOB: _____ SSN#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____

Employer Name: _____

INSURANCE INFORMATION:

Primary Insurance:

Primary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____

ID Number: _____ Group Number: _____

Secondary Insurance:

Secondary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____

ID Number: _____ Group Number: _____

