PATIENT INFORMATION

Patient Name: ______________________________ Date: ______________

Gender: __________ Single ❒ Married ❒ Birth Date: ______________

Phone (Home): ______________ (Work): ______________ Ext. ______

Cell Phone ______________ Pager ______________ Best time to call: ______________

Preferred appointment times: ❒ Morning ❒ Afternoon **SSN#** ______________

Address ______________________________

____

Place of Employment ______________________________

Who is responsible for this account ______________________________

Name of Dental Insurance Company______________________ Group # ______________

SPOUSE / EMERGENCY & INSURANCE CONTACT INFORMATION

Relationship to patient is: ❒ the patient's spouse ❒ parent ❒ family member ❒ other

Name______________________________

Address: ______________________ Birth date: ______________

Phone (Home): ______________ (Work) ______________ Ext: ______ Cell # ______________

Place of Employment: ______________________________

Social Security #: ______________________________

HEALTH INFORMATION

- ❒ **ADD/ADHD**
- ❒ AIDS/HIV
- ❒ Allergy to Codeine,
- ❒ Penicillin
- ❒ Sulfa
- ❒ Other __________
- ❒ Alzheimer's Disease
- ❒ Alcohol/Drug Abuse
- ❒ Anaphylaxis
- ❒ Anemia
- ❒ Antibiotic Prophylaxis
- ❒ **Anxiety**
- ❒ **Arthritis**
- ❒ Artificial Joints
- ❒ Asthma
- ❒ Blood Disease
- ❒ Bruises Easily
- ❒ **Cancer History**
- ❒ **Chemotherapy**
- ❒ Chest Pain
- ❒ **Compromised Immune System**
- ❒ **Constipation**
- ❒ Dental Phobia
- ❒ **Depression**
- ❒ **Diabetes**
- ❒ **Digestion Problems**
- ❒ **Diverticulitis**
- ❒ **Dizzy Spells**
- ❒ Dry Mouth
- ❒ Epilepsy
- ❒ Fainting Episodes
- ❒ **Fatigue**
- ❒ Free Bleeder
- ❒ Glaucoma
- ❒ Gout
- ❒ **Hayfever/Allergies**
- ❒ **Headaches**
- ❒ Head Injuries
- ❒ Heart Attack
- ❒ **Heart Burn**
- ❒ Heart Condition
- ❒ Heart Murmur
- ❒ Heart Surgery
- ❒ Hepatitis
- ❒ **High Blood Pressure**
- ❒ **High Cholesterol**
- ❒ **High Triglycerides**
- ❒ Hives/Skin Rash
- ❒ Hormone Replacement
- ❒ Implant Prothesis
- ❒ **Inner Ear Infections**
- ❒ **Insomnia**
- ❒ Irregular Heartbeat
- ❒ **Irritable Bowel Syndrome**
- ❒ Jaundice
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Lung Disease
- ❒ Lupus
- ❒ **Memory Loss**
- ❒ Menopause
- ❒ Mental Disorders
- ❒ Mitral Valve Prolapse
- ❒ Nervous Disorders
- ❒ **Obesity**
- ❒ Osteoporosis
- ❒ Pacemaker
- ❒ Parkinson's Disease
- ❒ Pregnancy Complication
- ❒ Pregnant? Yes No Due Date________
- ❒ Premenstrual Syndrome
- ❒ Prostate Problems
- ❒ Radiation Treatment
- ❒ Respiratory Problems
- ❒ Respiratory Infections
- ❒ Rheumatic Fever
- ❒ Rheumatism
- ❒ Seizures/Convulsion
- ❒ Shortness of Breath
- ❒ **Sinus Problems**
- ❒ **Sleep Problems**
- ❒ **Smoker**
- ❒ **Stressed Out**
- ❒ Stroke History
- ❒ **Sweet Snack Habit**
- ❒ Swelling of the Ankles
- ❒ Thyroid Disease
- ❒ TMJ Problems
- ❒ Tooth Grinding/ Clenching Habit
- ❒ Tuberculosis
- ❒ Tumors
- ❒ Ulcers
- ❒ Venereal Disease
- ❒ **Weight Management Problems**
- ❒ Other

• Have you ever 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 current medication** you take (prescription & over-the-counter) and **reason** for taking:
(example: insulin (diabetes)

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

DENTAL INFORMATION

Yes	No	
❒	❒	Do your gums bleed when you brush?
❒	❒	Are your teeth sensitive to cold, hot, sweets or pressure?
❒	❒	Have you had any periodontal (gum) treatments?
❒	❒	Have you ever had orthodontic (braces) treatment?
❒	❒	Do you have headaches, earaches or neck pains?
❒	❒	Do you wear removable dental appliances?
❒	❒	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain ______________________

How would you describe your current dental problem?______________________

Date of your last dental exam______________________ Date of last dental x-rays ______________________

What was done at that time ______________________

How do you feel about the appearance of your teeth?______________________

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

X ______________________ Date: ______________________ BP: __________
Signature of patient, parent or guardian

______________________ Date: ______________________ BP: __________
Signature of patient, parent or guardian (updated medical history)

______________________ Date: ______________________ BP: __________
Signature of patient, parent or guardian (updated medical history)

______________________ Date: ______________________ BP: __________
Signature of patient, parent or guardian (updated medical history)

CONSENT FOR SERVICES and RELEASE OF INFORMATION

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon the reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patientís account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay any of the reasonable value/values associated with these services. The payment is to be paid of said services, to said Doctor, or his assignee, at the time said services are rendered.

_________ I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

_________ I grant my permission to you or your assignee, to disclose and/or transfer any personal information pertaining to my diagnosis and/or treatment. I understand that each doctor must obtain the same disclosure according to the provisions stated in the Health Insurance Portability and Accountability Act (HIPAA). I have been offered a copy of this office's notice of privacy practices.
I have read the above conditions of treatment and agree to their content.

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all information on this sheet and I have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

X ______________________ Date: ______________________
Signature of patient, parent or guardian