PATIENT INFORMATION

Date

Patient Name _____ _____ ___ _____
Last First MI Preferred Name

Title _____ Gender ☐ Male ☐ Female
Mr/Ms/Mrs/Dr,etc

Family Status ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date - - SSN - -

Email Address _____

Phone _____ _____ ___ _____
Home Work Ext Cell

Address _____ _____ ___ _____
Street City State Zip

Whom may we thank for referring you? _____

EMPLOYER

Employer Name _____

Employer Address _____

_____
City State Zip

This office utilizes mail, telephone, text & email notifications to communicate appointment reminders & other treatment or business information. If you would like to opt out of any of these forms of communications, please list: _____

THE INFORMATION I HAVE PROVIDED IS ACCURATE. I UNDERSTAND I AM RESPONSIBLE FOR NOTIFYING THE OFFICE REGARDING ANY CHANGES IN THIS INFORMATION.

I CONSENT TO RECEIVING ELECTRONIC COMMUNICATIONS, UNLESS OTHERWISE NOTED ABOVE.

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES POLICY (HIPAA) AS SET FORTH BY THIS OFFICE.

Signature _____ Date _____

DENTAL INSURANCE

Insured's Name _____ Last _____ First _____ MI _____ Preferred Name

Insured's Birth Date ___ - ___ - ___ ID# _____ Group# _____

Insured's Address
(if different from patient's) _____

_____
City State Zip

Insured's Employer _____ Phone _____

Insured's Employer Address
(if different from patient) _____

_____
City State Zip

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

Insurance Plan Name _____

Insurance Address _____

_____
City State Zip

IMPORTANT: We file insurance as a courtesy to our patients.
We do not base our clinical exam or treatment plan on what your insurance does or does not cover.
OUR POLICY IS AS FOLLOWS:
1. The portion collected on the date of service is an estimate based on the information provided by your insurance provider.
Any balance remaining after insurance has processed the claim will be the responsibility of the patient.
A parent who presents a dependent for treatment is responsible for payment. We do not bill a third party.
2. Insurance companies have yearly and lifetime maximums. It is entirely your responsibility to keep track of this.
If you have received services with another provider, you may have less benefits available than what is represented on the information we receive from your insurance.
3. It is the responsibility of the patient to determine if our office is within their insurance network.
4. We will assist you in filing your claims and collecting payment from your insurance company. We are NOT OBLIGATED to do so and reserve the right to request payment from you regardless of the insurance status. We file primary insurance only.

- ▼ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper care.
- ▼ I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information.
- ▼ I authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS ABOUT THE INSURANCE POLICIES OF THIS OFFICE.
I HAVE RECEIVED A COPY OF THIS STATEMENT FOR MY RECORDS.

Signature _____ Date _____

MEDICAL HISTORY

Although dental personnel primarily treat the area around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you are taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name: _____ Phone ___ - ___ - ____ Birthdate: ___ / ___ / ____

Current Physician: _____ Phone ___ - ___ - ____ Last Exam: ___ / ___ / ____

Physician Address: _____
Street City Zip

	Have	Had	Family History
Heart Problems	☐	☐	☐
Chest pain	☐	☐	☐
Shortness of breath	☐	☐	☐
Blood pressure problem	☐	☐	☐
Heart murmur	☐	☐	☐
Heart attack	☐	☐	☐
Congestive heart failure	☐	☐	☐
Congenital heart disease	☐	☐	☐
Taking heart medication	☐	☐	☐
Rheumatic fever	☐	☐	☐
Pacemaker	☐	☐	☐
Artificial heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Blood Problems			
Abnormal bleeding	☐	☐	☐
Blood disease (anemia)	☐	☐	☐
Blood transfusion	☐	☐	☐
Allergy Problems	☐	☐	☐
Sinus problems	☐	☐	☐
Gastrointestinal Problems			
Ulcers	☐	☐	☐
Gerd	☐	☐	☐
Acid reflux	☐	☐	☐
Heartburn	☐	☐	☐
Kidney or bladder problems	☐	☐	☐
Frequent Diarrhea	☐	☐	☐
Bone or Joint Problems			
Arthritis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Joint replacement	☐	☐	☐
Respiratory Problems			
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
COPD	☐	☐	☐
Emphysema	☐	☐	☐
Tuberculosis	☐	☐	☐
Frequent cough	☐	☐	☐
Diabetes			
Insulin dependent	☐	☐	☐
Urinate more than 6 times a day	☐	☐	☐
Thirsty or dry mouth	☐	☐	☐
Head injury	☐	☐	
Frequent or severe headaches	☐	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐	☐
Stroke(s)	☐	☐	☐
Alzheimers	☐	☐	☐
Depression	☐	☐	☐

	Have	Had	Family History
Cancer / Tumor	☐	☐	☐
Type			
Chemotherapy, what kind	☐	☐	
Radiation	☐	☐	
Autoimmune disease	☐	☐	☐
Lupus	☐	☐	☐
Inflammatory disease	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B	☐	☐	☐
Hepatitis C	☐	☐	☐
HIV-positive/AIDS	☐	☐	☐
Herpes or other STD	☐	☐	☐
Kidney dialysis	☐	☐	☐
Weight loss	☐	☐	☐
Anemia	☐	☐	☐
Jaundice, liver trouble	☐	☐	☐
Glaucoma	☐	☐	☐
Thyroid problems	☐	☐	☐

	Yes	No
Do you wear contact lenses?	☐	☐
Sleep Apnea	☐	☐
Do you snore?	☐	☐
if so, do you use a CPAP?	☐	☐
Do you smoke?	☐	☐
if so, how much?		
are you interested in quitting?	☐	☐
Do you drink alcohol?	☐	☐
if so, how much?		
History of alcohol or drug abuse	☐	☐
Do you have a contract with pain clinic?	☐	☐
Do you have any disease, condition or problem not listed?	☐	☐
Do you have a latex allergy?	☐	☐

List all vitamins/supplements & over the counter medications

List all prescription medications you are taking

List all medication allergies

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information will be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Signature of Patient, Parent or Guardian Date