Drs. Onstott, Farris & Fisher Family Dentistry

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Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

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

If college student, F.T/P.T., name of school _____ City _____ State _____

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

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 _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State. _____ Zip _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

X_____ _____
Signature of patient (or parent, if minor) **Patient number**

MEDICAL HISTORY

Physician_____ Date of Last Visit_____
Address_____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Are you pregnant? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____
Please list all medications that you are currently taking: _____
_____

DENTAL HISTORY

Reason for your visit _____ Date of last visit_____
What concerns you most about your teeth? _____
Yes No Are you presently in any dental pain?_____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you like the appearance of your smile? _____

OFFICE POLICIES

FEES - The fee for your treatment is based on the complexity of your case. You will be informed of the fee after your examination.

PAYMENT – It is our policy that payment for all services rendered be made in full AT or BEFORE the completion of treatment. We realize that some dental treatment may be of an emergency nature, and that patients may not always be prepared for unexpected dental expenses. To assist you in this regard, we gladly accept VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

DENTAL INSURANCE – If you believe that your treatment is covered by a dental insurance policy, we will be happy to assist you in completing the necessary forms. Please understand that while this is done for your convenience, **we consider each patient to be responsible for their entire balance regardless of their insurance coverage.**

If your insurance carrier will reimburse you directly, we ask that your account with our office be paid in full when treatment is rendered.
If you request the insurance carrier to reimburse our dental office, we ask that 50% of the fee be paid when the insurance is submitted. Your account will be adjusted immediately if a credit balance is created after an insurance payment.

MISSED APPOINTMENTS – Confirmed appointments require 24 hour notice if you are unable to be present. You will be assessed a MISSED APPOINTMENT FEE ($50 for HYGIENE VISIT and/or $75 for DOCTOR VISIT.)

X _____ _____
Signature of Patient/ Guardian **Date**

I have read and reviewed the information given above, previously provided to the office, and have no changes to make to it.

X _____ _____
Signature of Patient/ Guardian **Date**

I have read and reviewed the information given above, previously provided to the office, and have no changes to make to it.

X _____ _____
Signature of Patient/ Guardian **Date**

I have read and reviewed the information given above, previously provided to the office, and have no changes to make to it.

X _____ _____
Signature of Patient/ Guardian **Date**

I have read and reviewed the information given above, previously provided to the office, and have no changes to make to it.

X _____ _____
Signature of Patient/ Guardian **Date**