maineemergencydentist

PATIENT INFORMATION

First Name_____ M.I.____ Last Name _____ BirthSex: ❑ M ❑ F

Street _____ City _____ State _____ Zip _____

Birth Date_____ Age_____ Soc. Sec. #_____ Employer _____

Phone#1 (____) _____ Phone#2 (____) _____ Email: _____

Referring office _____ Dentist _____Orthodontist _____

Medical Doctor _____ Medical Specialist _____ Pharmacy _____

IF PATIENT IS A MINOR/UNDER GUARDIANSHIP, accompanying parent/guardian information: ❑Father ❑ Mother ❑ Other (relation) _____
First Name _____ Last Name _____ S.S.# _____ Birth Date_____
Cell (____) _____ Home (____) _____ Work (____) _____
Street _____ City _____ State ____ Zip _____

*I AUTHORIZE THE RELEASE OF MY MEDICAL AND FINANCIAL RECORDS TO THE FOLLOWING:

Name _____ Relationship _____ Phone# _____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cancer _____
- ❑ Chemotherapy
- ❑ Chest pain
- ❑ Chronic cough
- ❑ Chronic headaches
- ❑ Circulatory problems
- ❑ Damaged Heart Valves
- ❑ Diabetes
- ❑ Emphysema
- ❑ Endocrine Abnormalities
- ❑ Excess weight loss/gain
- ❑ Fainting tendency
- ❑ Glaucoma
- ❑ Heart murmur
- ❑ Heart attack/surgery _____
- ❑ Hepatitis/liver trouble
- ❑ High/low blood pressure
- ❑ Infectious disease
- ❑ Jaundice
- ❑ Kidney problems
- ❑ Lung problems
- ❑ Malignancy(tumor)
- ❑ Osteoporosis/Osteopenia
- ❑ Pacemaker
- ❑ Porphyria
- ❑ Psychiatric treatment
- ❑ Radiation therapy
- ❑ Rheumatic fever
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Seizures/Epilepsy
- ❑ Sleep Apnea
- ❑ Stroke/TIA
- ❑ Thyroid condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal disease

Other illnesses or diseases: _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

Surgical history: _____ _____ _____ _____ _____

Please list any prescribed medications you are currently taking: _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Please list any allergies that you have: _____ _____ _____ _____

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Are you allergic to any medication, local anesthetic, drug or food?	Y	N
Is your general health good?	Y	N
Have you been admitted to the hospital during the *past two years*, other than for *routine care*?	Y	N
Have you had any diseases, serious illnesses, operations, hospitalizations *within the past five years*?	Y	N
Are you taking any medications currently? (Please provide med list to scan, if available)	Y	N
Are you presently taking steroids, blood thinners or insulin?	Y	N
Are you taking or have you ever taken a BISPHOSPHONATE or ANTIRESORPTIVE medication? Prolia, Fosamax, Actonel, or Boniva for osteoporosis Xgiva, Aredia, Reclast or Zometa to prevent cancer spread?	Y	N
Have you ever had any excessive or abnormal bleeding?	Y	N
Have you or a family member ever had a complication from a general anesthetic?	Y	N
Have you ever had a complication from a local anesthetic?	Y	N
Women: Are you pregnant? If yes, how many months? _____ Are you nursing? _____	Y	N
Do you use? ❑ Tobacco If yes, how much? _____ ❑ Nicotine If yes, how much? _____ ❑ Marijuana If yes, how much? _____ ❑ Alcohol If yes, how much? _____ ❑ NO to all ❑ Other substances If yes, how much? _____		
Do you or have you ever taken narcotics?	Y	N
Do you wear dentures or contact lenses?	Y	N
Do you have any artificial joints or implanted devices? If yes, what kind: _____ When: _____	Y	N
Is there anything else we should know about your medical history? _____	Y	N
For office use only: BP: _____/_____ P: _____		

HIPAA ACKNOWLEDGEMENT I acknowledge maineemergencydentist's Notice of Privacy Practices and have been made aware that a copy is available in the event that I would like to request one.

HEALTH HISTORY The above health questionnaire is true to the best of my knowledge. Further, I agree to be responsible for all costs of treatment to which I consent.

FINANCIAL POLICY

- ***Full payment is due at time of service.***
- If requested, a dental reimbursement form provided by your insurance company can be completed so you can submit to your insurance company.
- The patient, or legal guardian for minors, is responsible for all amounts not paid at time of service.
- If after 90 days there is a balance on the account, the patient or legal guardian is responsible for the balance, all rebilling charges, interest charges, collection costs and attorney fees.
- If you do not provide at least 24 hours notice when canceling or rescheduling a surgery appointment, you must pre-pay 50% prior to making another appointment and/or you will not be rescheduled.
- THE INDIVIDUAL PAYING FOR THE SERVICES RENDERED MUST BE PRESENT IN OUR OFFICE AT THE TIME OF PAYMENT.
- Patient payments can be made by cash or credit card.

By signing below, I have read, understand and agree to this financial policy. I agree that I have acknowledged the offices HIPAA policy, and I certify that my medical history is accurate to the best of my knowledge.

SIGNATURE OF PATIENT (PARENT/GUARDIAN IF MINOR) PRINT NAME DATE