Patient Information

Patient Name________________________________ Parent Name (if minor)____________________

Street________________________________ City________________ State________ Zip__________

Home Phone__________________ Cell Phone__________________ Birth Date____________________

Married ☐ Single ☐ Divorced ☐ Widow ☐ SS#__________________ Occupation ________________

Employer____________________________ Business Phone____________________ Ext.__________

Medical History

1. Are you in good health? YES NO

   Physician______________________ Number______________ Date of Last Physical ______________

2. Please list medications you are currently taking (including aspirin)______________________

   ____

3. ALLERGIES (check all boxes that apply)

Penicillin		Advil		Other Anesthesia		Chestnuts	
Erythromycin		Aspirin		Latex		Avocados	
Iodine		Novocain		Bananas		Kiwi	

Other:____

4. Do you premedicate with antibiotics for heart problems or joint replacements prior to dental appointment? YES* NO

   *If yes, what is your current antibiotic regimen?____________________________________

5. Do you have any prosthetic replacements (e.g. heart valve, hip, etc.)? YES* NO

   *If yes, please list:__________________________

7. WOMEN: Are you pregnant?________________ Nursing?______________ Birth Control Pill______________

8. In case of emergency, contact____________________________ Phone__________________ Relation__________

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL BOXES THAT APPLY)

Heart Attack		High Blood Pressure		Tuberculosis		Claustrophobia	
Heart Murmur		Low Blood Pressure		Liver Disorder		Dental Phobia	
Rheumatic Fever		Colitis		Hemophilia		TMJ Problem	
Endocarditis		Diabetes		Bleeding Disorder		Headaches	
Mitral Valve Prolapse		Cancer		Asthma/Shortness of breath		Migraines	
Artificial Heart Valve		Radiation Therapy		AIDS or HIV positive		Neuralgia	
Angina		Epilepsy		Immune Disorder		Fibromyalgia	
Stroke		Hepatitis, TYPE:		Ulcers		Mental Disorder	
Cardiac Pacemaker		Arthritis		Chemical Dependency		Psychiatric Care	
Anemia		Glaucoma		Sinus Problems		Thyroid	

OTHER CONDITIONS:____

AUTHORIZATION AND RELEASE

I certify the personal, medical and insurance information I have provided is correct, to the best of my knowledge:

Patient/Guardian____ Date________________ Staff Initial_____

(SIGNATURE)

Insurance Information

Provide this information if YOU have dental insurance through your place of employment:

Name of insured_______________ your place of employment_______________

Insurance company name_______________ Group #_______ ns. Co. phone #_______________

Insurance company address_______________________________________

Member ID # or SS # of insured (required)_______________ Birth date of insured (required)_______________

Provide this information if YOUR SPOUSE has dental insurance coverage:

Name of insured_______________ his/her place of employment_______________

Insurance company name_______________ Group #_______ Ins. Co. phone #_______________

Insurance company address_______________________________________

Member ID # or SS # of insured (required)_______________ Birth date of insured (required)_______________

IF YOU DO NOT HAVE INSURANCE OR IF YOU DO. HOW WILL YOU PAY FOR YOUR PORTION OF THE FEE?

☐ Cash ☐ Check ☐ Credit card

Card type_______________ card #_______________ exp._______________

Payment Terms and Office Policies

1. Full payment is due at the time of service, unless other terms have been made before treatment was initiated.
2. The terms of your dental coverage were determined by the type of plan your employer was willing to purchase for you and have nothing to do with our office. You are responsible for any balance that remains after your insurance payment.
3. Any balance due past 30 days will be automatically billed to your charge account on file.
4. Account balances past due more than 30 days will be assessed a monthly rebilling fee of $5 per month and/or a finance charge of 1.8% monthly (18% APR).
5. In cases of payment default the patient agrees to pay any accrued interest, collection costs and attorney fees, incurred to effect collection of the account. An entry may be placed on your credit record, which remains for a number of years.
6. We reserve a significant amount of time for your appointment so treatment can be performed patiently, carefully and perhaps be completed in one visit. It can be very difficult to fill an appointment of the length of time we reserve especially for you, if you do not give us adequate notice of an inability to arrive as scheduled. There is a $95 fee for a failed appointment or cancellation without 48 hours notice.
7. There is a $25 fee for checks returned for insufficient funds.

Authorization and Release

I certify the personal, medical and insurance information I have provided is correct, to the best of my knowledge. I certify that I have read and understand the above information and will ask any and all questions I believe are necessary for my understanding. I authorize the release of any information, including the diagnosis of my problem and the records of my treatment, or examination rendered tó me or my child, during the period of such dental care, to third party payors and/or health practioners, in accordance with HIPAA regulations. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I have read and accept the Payment Terms and Office Policies section of this record.

Patient/guardian_______________________ _______________ staff initial__________

(SIGNATURE) (DATE)

Updates:_______________________ _______________ staff initial__________

_______________________ _______________ staff initial__________

_______________________ _______________ staff initial__________

_______________________ _______________ staff initial__________

_______________________ _______________ staff initial__________