PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Wireless Carrier_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:

Financial Agreement

Last Name: First Name: Birthdate:

Date:

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

I agree to let this office run a credit report. If no, then all fees are due at time of service.

☐ Yes
☐ No

Patient Name:
Birthdate:

Medical History for New Patient

Name of Medical Doctor: _____ City/State: _____

List all medications that you are now taking, including herbal remedies and regular doses of aspirin:

_____ _____

_____ _____

_____ _____

Tobacco use? Including Vaping and E-Cigarettes? Y N Please specify: _____

Have you ever taken prescription medications for weight loss, such as Fen-Phen, Pondimen or Redux?

_____

Have you ever taken(or are you scheduled to start taking) Anti-Osteoporosis/Bisphosphonates drugs, such as Ardeia, Zometa, Fosamax, Actonel, Boniva, Reclast, Didronel, Prolia, XGeva or Skelid? _____

Are you aware of any allergic or adverse reaction to any substance or medication? Y N
If yes, please specify:

Have you been admitted to the hospital in the last 5 years? Y N

Women: Are you pregnant or think you may be pregnant? Y N Nursing? Y N

Do you use birth control prescriptions? Y N

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Blood Disorders (Hemophilia, Sickle Cell Disease, Anemia)
☐	☐	Sexually Transmitted Diseases	☐	☐	Kidney Disease
☐	☐	Congenital Heart Disease	☐	☐	Liver Disease
☐	☐	Heart (Surgery, Disease, Attack	☐	☐	Chemotherapy and/or Radiation Therapy
☐	☐	High/Low Blood Pressure	☐	☐	Psychiatric Treatment
☐	☐	Cancer/Tumors	☐	☐	Hayfever or Sinus Trouble
☐	☐	Diabetes	☐	☐	Cold Sores or Fever Blisters
☐	☐	Heart Murmur/ Mitral Valve Prolapse	☐	☐	Dizzy Spells or Fainting
☐	☐	Arthritis/ Rheumatism	☐	☐	Rheumatic Fever
☐	☐	Stroke	☐	☐	Blood Transfusion
☐	☐	Artificial Joint (hip or knee, etc.)	☐	☐	Hepatitis A, B or C
☐	☐	Epilepsy or Seizures	☐	☐	Sexually Transmitted Diseases
☐	☐	Chronic Cough/ Emphysema/ Tuberculosis	☐	☐	AIDS/ HIV Positive

Do you have or have you had any disease, condition or problem not listed? If so please specify

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who is authorized to release such information to you. I will notify the doctor of any change in my health or medication as soon as I am aware.

_____ _____

Signature Date

Notice of Privacy Policies

Last Name: First Name: Birthdate:

Date: 05/11/2020

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.
I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

_____

_____

_____