Patient Information Form

Date: ________________

Patient Name: (First) ________________________ (Last) ____________________________ (MI) _____

Social Security: ____________________ Date of Birth: ___________________ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Child

Cell #:(____)________________ Home #:(____)____________________ Work #:(____)____________________

Email:____

Address: ____ ___________

Street Apt #

_____________________________ ___________ _________________________

City State Zip Code

Name of Referring Doctor: _________________________________ Phone Number:(____)__________________

FIRST NAME LAST NAME

Primary Dental Insurance Information

Insurance Company Name: _______________________________ ID Number: _________________________

Insured Name: (First) ________________________ (Last) ____________________________ (MI) _____

Social Security Number: _____________________ Insured's Date of Birth: ___________________

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

Secondary Dental Insurance Information

Insurance Company Name: _______________________________ ID Number: _________________________

Insured Name: (First) ________________________ (Last) ____________________________ (MI) _____

Social Security Number: _____________________ Insured's Date of Birth: ___________________

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

Primary/Secondary Medical Insurance Information

Insurance Company Name: _______________________________ ID Number: _________________________

Insured Name: (First) ________________________ (Last) ____________________________ (MI) _____

Social Security Number: _____________________ Insured's Date of Birth: ___________________

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

I understand my rights outlined in the Notice in relation to the use or disclosure of my protected health information. A copy is available to me upon request.

X__________________________ X__________________________ __________________________

Patient's name (printed) **Patient's Signature** **Date**

X__________________________ X__________________________ __________________________

Patient's representative's name **Representative's Signature** **Relationship to Patient**

Patient Medical History

Physician ____________ ____________ Office Phone(____)____________ Date of Last Exam ____________
FIRST NAME LAST NAME

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ____________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
3a. Bisphosphonates (IV or Pills) If yes, what medication(s) are you taking? ____________	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

1. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐

10. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever /Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
Aids or HFV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other	☐	☐

Patient Dental History

Name of Previous Dentist and Locaton ____________ ____________ Date of Last Exam ____________
FIRST NAME LAST NAME

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Have you had any head, neck, or jaw injuries?	☐	☐
8. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement ____________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for seivices. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

Signature of patient (or parent if minor)

Doctor's Comments ____

____

____________________ Signature ____________________ Date ____________

Office Financial Policy

The fees in our office are based on the care, skill, time and judgment necessary to help treat your condition. The fee(s) for your particular treatment will be discussed with you prior to any treatment. Payment for treatment is due at the time of service. We accept Cash, MasterCard, Visa, and American Express. Outside dental financing plans such as Care Credit are available.

Insurance Benefits

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary greatly, we can only estimate your coverage but cannot guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. We will accept cash, Visa, MasterCard, or American Express. As assistance to our patients, we will bill insurance companies for services and allow them 45 days to render payment.

We will accept the assignment of benefits from the insurance companies for the insured portion for the first 60 days. However, it is very costly to carry amounts beyond this length of time. Therefore, after 60 days you are responsible for the entire balance, paid-in-full. If the balance is not paid interest will be automatically charged on accounts aged over 60 days at the rate of 18% APR.

Consent

I have read the above conditions of payment and agree to their content. I grant my permission to you or your assignee, to telephone me at home or at my place of work to discuss matters regarding this form. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on behalf of my dependants.

____ __________________

Patient/Parent/Guardian – Printed Name Date

____ __________________

Patient/Parent/Guardian – Signature Date

Our patients and our relationships with our patients are very important to us. If you have any questions or need assistance, our courteous staff is always available to answer them.