PATIENT INFORMATION

DATE ____________________

NAME ____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

SOCIAL SECURITY # ______________________________

ADDRESS ____
STREET APT. # CITY STATE ZIP

BIRTHDATE ______________________ TELEPHONE ______________________________
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER ______________________ ADDRESS ______________________

IF FULL TIME STUDENT, SCHOOL NAME ______________________ GRADE ________

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	SECONDARY INSURED
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME WORK CELL E-MAIL	HOME WORK CELL E-MAIL
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO	EMPLOYER DENTAL INS. CO
SS# SUBSCRIBER # GROUP #	SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name ______________________________

Address ______________________________

City/State/ZIP ______________________________

Telephone # ______________________________

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X ______________________________
Patient or Responsible Party

____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐ Yes ☐ No

Whom may we thank for referring you to our office?

____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ Yes ☐ No

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐ VISA ☐ MC ☐ OTHER)

Card # ______________________ Exp. Date __________

☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ______% per month (or a minimum charge of $_______ for a balance under $_________) which is an annual percentage rate of _______% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

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IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No Aspirin
Yes / No Penicillin or other antibiotics
Yes / No Nitrous oxide
Yes / No Valium or other sedatives
Yes / No Latex
Yes / No Local anesthetic
Yes / No Codeine or other narcotics
Yes / No Food
Yes / No Metal

Others: ______

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Anti-Depressants
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Herbal Supplements
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all prescription medications: ______

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? ______
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: ______

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: ______

Yes / No Have you ever taken Fen-Phen? If YES, when: ______

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: ______ Date: ______

Physician's Name: ______ Phone Number: ______

Whom would you like us to contact in case of an emergency?

Name: ______ **Relationship**: ______ **Phone Number**: ______

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) ______ Date ______ Signature of Dentist ______ Date ______