Patient Information Form

Date _____

Name _____ Preferred Name _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____ ☐ Male ☐ Female

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school _____ City _____ State _____

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Previous Dentist _____(___)_____ Last Dental Exam _____ Last Dental X-rays _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

Amount of your deductible _____ How much have you used? _____ Max annual benefit _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State _____ Zip _____

Amount of your deductible _____ How much have you used? _____ Max annual benefit _____

X _____ _____

Signature of patient (or parent, if minor) **Patient account number**

MEDICAL HISTORY

Physician _____ Date of Last Visit_____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

☐ Nerve pills ☐ Pain pills (including aspirin) ☐ Muscle Relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin

☐ Meds for Osteoporosis Have you ever taken: Bisphosphonates (ex. Aredia / Fosamax) ☐ yes ☐ no Phen-fen/Redux ☐ yes ☐ no

Yes No Are you taking any **other medication**(s)? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only:

Yes No Are you pregnant?_____

Are you allergic to any of the following? Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics

☐ Foods: _____ ☐ Others: _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal Bleeding/Hemophilia	Chest Pains	Heart Surgery/Pacemaker	Respiratory Problems
Alcohol / Drug Abuse	Congenital Heart Defect	Hepatitis/Liver Problems	Rheumatic Fever
Anemia	Cosmetic Surgery	High /Low Blood Pressure	Scarlet Fever
Artificial Valves	Diabetes / Hypoglycemia	HIV+ / Aids / ARC	Severe / Frequent Headaches
Artificial Bones / Joints	Difficulty Breathing	Jaw Problems TMJ/TMD	Shingles
Arthritis / Rheumatism	Emphysema	Kidney Problems	Sinus Problems
Asthma or Hayfever	Epilepsy/Fainting/Seizures	Leukemia	Stomach Problems /Ulcers
Back Problems	Frequent Neck Pain	Liver Problems	Thyroid Problems
Bleeding Problems	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Cancer / Tumors	Heart Attack /Stroke	Nervousness or Disorders	Venereal Disease
Chemotherapy	Heart Murmur	Psychiatric Problems	X-Ray or Cobalt Treatment

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

Do you require pre-medication? ☐ yes ☐ no ☐ don't know

DENTAL HISTORY

Reason for your visit _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain?
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Have you ever experienced any unfavorable reaction to dentistry?
Yes No Have your wisdom teeth been removed?
Yes No Have there been any injuries to face, mouth, or teeth?
Yes No Are you a mouth breather?
Yes No Are you aware of your jaw clicking or popping?
Yes No Are you aware of clenching your teeth during the day?
Yes No Do you like the appearance of your smile?

OFFICE POLICIES

PAYMENT – It is our policy that payment for all services rendered is due in full at or before the completion of treatment. We realize that some dental treatments may be due to an emergency and patients may not always be prepared for unexpected dental expenses; to assist you in this regard, we gladly accept VISA, MASTERCARD, DISCOVER, and CareCredit or CitiHealth. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for all legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

AUTHORIZATION – I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

DENTAL INSURANCE – As a courtesy to you, we will file your visit to your insurance carrier. Please understand that while this is done for your convenience, **we consider each patient to be responsible for their balance regardless of their insurance coverage.** The estimated patient portion is due in full at the date of service.

MISSED APPOINTMENTS – Confirmed appointments require 24 hour notice if you are unable to be present.

AGREEMENT – I understand the above information and guarantee this form was completed correctly, to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes to the information I have provided.

X _____ _____

Signature of Responsible Party **Relationship** **Date**