Personal Information

Name:

Date: Birthdate: SSN:

Wishes to be called: Male ☐ Female ☐

E-Mail:

Mailing Address:

City: State: Zip Code:

Employer: Occupation: Referred by:

Home Phone: Work Phone: Cell Phone:

Emergency Contact

Name: Relationship: Phone:

Primary Insurance

Name of Insured:

Relationship to Patient:

Insured's Birthdate:

SSN:

Employer:

Insurance Company:

Group #:

Employee I.D. #:

Ins. Co. Address:

Yearly Maximum:

Deductible:

Secondary Insurance

Name of Insured:

Relationship to Patient:

Insured's Birthdate:

SSN:

Employer:

Insurance Company:

Group #:

Employee I.D. #:

Ins. Co. Address:

Yearly Maximum:

Deductible:

Responsible Party

Who Is responsible for the account?_____

Name:_____ Relationship to Patient:_____

Birthdate:_____ Driver's License #:_____

SSN:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other healthcare practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for any outstanding balances.

_____ _____

Signature of patient or parent if patient is a minor Date

Financial Arrangements

For your convenience we offer the following methods of payment. Please check the option you prefer.

Cash ☐ Personal Check ☐ Credit Card ☐

☐ I wish to discuss the offices payment policy

Patient Name:_____ Date:_____

Birthdate:_____ Patient #:_____

History of Present Illness

Location:_____ Severity:_____ Timing:_____

(Where is the pain?) (On a scale of 1-5) (When does the pain occur?)

Associated signs/symptoms:_____

(Problems pain causes)

Modifying Factors:_____

(What makes it better or worse?)

Past Medical History

Have you had the following: (circle "yes" or "no")

Measles	yes	no	Bladder Infections	yes	no	Low Blood Pressure	yes	no
Mumps	yes	no	Epilepsy	yes	no	Hemorrhoids	yes	no
Chickenpox	yes	no	Migraines	yes	no	Last Chest X-ray Date		
Whooping Cough	yes	no	Tuberculosis	yes	no	Asthma	yes	no
Scarlet Fever	yes	no	Diabetes	yes	no	hives/eczema	yes	no
Diphtheria	yes	no	Cancer	yes	no	AIDS/HIV	yes	no
Smallpox	yes	no	Polio	yes	no	Infectious Mono	yes	no
Pneumonia	yes	no	Glaucoma	yes	no	Bronchitis	yes	no
Rheumatic Fever	yes	no	Hernia	yes	no	Mitral Valve Prolapse	yes	no
Heart Disease	yes	no	Blood/Plasma Transfusion	yes	no	Stroke	yes	no
Arthritis	yes	no	Ulcer	yes	no	Kidney Disease	yes	no
Venereal Disease	yes	no	Bleeding Tendency	yes	no			
Hepatitis	yes	no	Back Trouble	yes	no	Other:_____		
Thyroid Disease	yes	no	High Blood Pressure	yes	no	_____		
Anemia	yes	no						

Currently Pregnant yes no Due Date:_____

Previous Hospitalizations/Surgeries/Serious Illness:_____

When:_____ Hospital/City/State:_____

Medication (prescription and non):_____

Patient Social History:_____

Alcohol Use	Never	Rarely	Moderate	Daily
Tobacco Use	Never	Rarely	Moderate	Daily
Excessive exposure to	Fumes	Dust	Solvents	Noise

Energy Drinks:_____ Last Date Drank:_____ Time:_____

Chewing Tobacco:_____ Last Time:_____

Coffee:_____ Last Date Drank:_____ Time:_____

Street Drugs	Never	Rarely	Moderate	Daily

Products containing nicotine, caffeine or street drugs can affect your blood pressure and effectiveness of the anesthesia. Please notify us of use of these so we can adjust your treatment accordingly.

Are you currently on pain management or in a drug rehabilitation program? yes no

Pain Management/Rehabilitation Doctor Name:_____ Phone:_____

Family Medical History

	Age	Diseases	If deceased cause of death
Father:			
Mother:			
Siblings:			

Review of Systems

Have you had the following: (circle "yes" or "no")

Constitutional Symptoms
Good general health yes no
Weight change yes no
Fever yes no
Fatigue yes no
Headaches yes no

Eyes
Eye disease/injury yes no
Wear glasses/contact yes no
Blurred/double vision yes no

Ears/Nose /Throat /Mouth
Hearing loss yes no
Earache/drainage yes no
Chronic sinus/rhinitis yes no
Nose bleeds yes no
Mouth sores yes no
Bleeding gums yes no
Bad breath/taste yes no
Sore throat yes no
Voice change yes no
Swollen glands yes no

Cardiovascular
Heart trouble yes no
Chest pain yes no
Palpitation yes no
Shortness of breath with walking/laying down yes no

Respiratory
Chronic/frequent coughs yes no
Spitting up blood yes no
Shortness of breath yes no
Wheezing yes no

Gastrointestinal
Acid reflux yes no
Loss of appetite yes no
Nausea/vomiting yes no
Abdominal pain yes no

Musculoskeletal
Joint pain yes no
Joint stiffness yes no
Joint swelling yes no
Muscle or joint weakness yes no
Back pain yes no
Cold extremities yes no
Difficulty walking yes no

Neurological
Frequent headaches yes no
Light headed/dizzy yes no
Convulsions/seizures yes no
Numbness/tingling sensations yes no
Tremors yes no
Paralysis yes no
Head injury yes no

Psychiatric
Memory loss yes no
Confusion yes no
Nervousness yes no
Depression yes no
Insomnia yes no
Suicidal thoughts yes no
Violent thoughts yes no

Endocrine
Hormone problem yes no
Glandular problem yes no
Heat/cold intolerance yes no
Dry skin yes no

Hematologic/Lymphatic
heal from cuts slow yes no
Bruising tendency yes no
Bleeding tendency yes no
Anemia yes no
Phlebitis yes no

Allergic/Immunologic
Penicillin or other antibiotics yes no
Morphine, Demerol or other narcotics yes no
Novocain or other anesthetics yes no
Aspirin/pain killers yes no
Tetanus/antitoxins yes no
Iodine/antiseptics yes no
Latex yes no

Food allergies

Environmental allergies
Is a premed needed yes no

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inorm the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of patient or parent if patient is a minor

Date

Doctors Review

Signature of Doctor

Date

Our Financial Policy

Responsible Party's Payment method:

All adult patients and parents or legal guardians of patients are financially responsible for their bill. We accept cash, check, credit card, and money order. If other options are needed please check with the front desk. Your method of payment:

☐ Cash ☐ Check ☐ Credit Card ☐ Money Order

☐ Other

Interest Charges and Missed Appointments:

Please be advised it is our policy to charge an interest rate of .88% for every month a payment is not received after 30 days a total of 10.5% annual rate. This applies to all balances including those left after insurance has paid. There will be a $50.00 missed appointment fee. If your appointment is not cancelled 24 hours in advance we will collect this fee before we can reappoint you again. If you arrive at your appointment more than 15 minutes late it is considered a broken or missed appointment and this fee will apply. Phone calls made in advance can prevent this fee. If there is 3 or more consecutively missed appointments dismissal from this office is a probability unless a valid reason is explained.

Co-Payment, Deductibles, and Remaining Balances:

You are ultimately responsible for the balance on your account. If you have insurance we expect an estimated co-pay of 20%-50% of the total bill at the time services are rendered. We also expect your yearly deductible at the time of your first visit. If the insurance does not pay their full estimated amount you are responsible for the remaining portion. We will be happy to bill your insurance company for you. But please be advised the dentist does not have a contract with the insurance company you do. It is your responsibility to see that they pay in a timely manner

Your patronage and confidence in us is greatly appreciated. Our goal is to provide you with the best possible service and maintain your valued confidence. Please let us know if there is anything more we can do for you or any questions you may need answered.

I understand these policies and agree to abide by these conditions.

Signature of patient or parent if patient is a minor

Date

PRIVACY PRACTIES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Birthdate:_____

_____ _____

Signature of patient or parent if patient is a minor Date