Patient, Pharmacy and Insurance Information **Date:**_____

Patient Information

First Name:_____ Middle Initial:_____ Last Name:_____

Street: _____ Zip:_____ City:_____ State:_____

Preferred Phone #:_____ Is this a mobile number? Yes No

Email Address:_____

Date of Birth:_____ Sex: Male Female

Social Security Number:_____

Emergency Contact:_____ Emergency Phone #:_____

Primary Language: English Spanish Other: _____

Responsible Party:_____

First Name:_____ Middle Initial:_____ Last Name:_____

Street:_____ Zip:_____ City:_____ State:_____

Date of Birth:_____

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy_____ Phone #:_____

Primary Dental Insurance_____

Subscriber Information:

First Name:_____ Middle Initial:_____ Last Name:_____

Employer Name:_____ Insurance Company:_____

Subscriber ID/Policy Number:_____ Group/Contract Number:_____

Date of Birth:_____

Patient Relationship to Subscriber: Child Spouse Self Other Dependent

Subscriber SSN:_____

Secondary Dental Insurance_____

Health History

Reason for Visit: Broken Tooth Check-up Cosmetic Dentures Tooth Pain Other:_____

Are you under the care of a primary physician? Yes No

Primary Physician's Name:_____ Physician's Phone Number:_____

Date of Last Physical:_____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? Yes No

Have you ever been hospitalized within the last 3 years? Yes No

If yes, please list when and why:_____

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)? Yes No How Long? _____

Do you require antibiotics prior to dental procedures? Yes No

If yes, what do you normally take? _____

Are you allergic or have you had an adverse reaction to any of the following?

☐ None ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex Metals ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Local Anesthetic

List any medications you are taking including non-prescription drugs and herbals/vitamins:

_____

_____

_____

Check any conditions that apply to you:

- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Pins
  *Type____
  * Date placed_____
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Lung Disease/COPD
- ☐ NON- Dental Implants
  *Type_____
- ☐ Organ Transplant
  *Type_____
- ☐ Pacemaker
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
  *Type_____
- ☐ Chemotherapy
- ☐ Dementia
- ☐ Diabetes
- ☐ Lupus
- ☐ Mobility Impairment
- ☐ Pain Management
- ☐ Heart Surgery
  *Date_____
- ☐ Heart Trouble
  *Type_____
- ☐ Hepatitis
  *Type_____
- ☐ High Blood Pressure

- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Low/High Blood Pressure
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Rheaumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Visual Impairment
- ☐ Other _____

*If Patient is a minor: Height _____ Weight _____

Dental History

Date of Last Dental Visit:_____ Date of Last Dental X-ray:_____

Oral Health

Have you ever been treated for periodontal (gum) disease? Yes No

Have you ever had Novocaine or other local anesthetic? Yes No

Do you prefer to use Laughing Gas for your dental procedures? Yes No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? Yes No

*Age of dentures:_____

Please check any conditions that apply to you below:

__Pain In Jaw(TMJ) __Teeth Grinding/Clenching __Use Tobacco Products __Mouth Sores

__Sensitive Teeth __Broken/Loose Teeth __Difficulty Chewing/Swallowing __Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? Yes No *Estimated Delivery Date:_____

Are you Nursing? Yes No Are you taking any birth control prescriptions? Yes No

To the best of my knowledge, all of the answers and information provided are true and correct. If I ever have any changes in my health I will inform the doctor at my next appointment without fail. I authorize this office to contact me by any or all of the phone numbers I have listed, or post card regarding dental appointments.

Financial Obligation:

-As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends on reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All the emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

-Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that all charges will be paid by an insurance company.

- I agree to pay all collection costs and reasonable attorney fees if my account becomes delinquent and should be turned over for collections.

Signed_____Date_____

Due to increasing mailing and overhead expense we are NO LONGER mailing out monthly billing statements. We will mail the first billing statement complimentary and we will expect payment in full on this billing. There-after we will charge a $10.00 statement fee which will be added to your balance for each additional statement we have to generate and mail. Please contact our office to discuss payment options if balance cannot be paid in full at first billing.

Signature of Patient, Parent or Guardian_____

If you desire monthly payments, we can set you up a payment booklet