Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

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

Email _____

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 _____

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

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

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.# _____

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 _____

X_____

Signature of patient (or parent, if minor)

MEDICAL HISTORY

Patient Name_____

Physician_____Date of Last Visit_____
Address_____Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Do you need Antibiotics before Dental appointment? Why? _____
Yes No Are you taking any medication? _____
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? _____
Yes No Are you taking any Osteoporosis medication? If yes what kind?_____

ALLERGIES

Yes	No	Latex	Yes	No	Codine	Any other Allergies:
Yes	No	Penicillin	Yes	No	Tetracycline	_____
Yes	No	Aspirin	Yes	No	Sulfa Drugs	
Yes	No	Pain Killers	Yes	No	Sedatives	

Please List Medications if any taken below:

_____

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

Abnormal bleeding/Hemophilia	Diabetes	Herpes	Radiation/Chemotherapy
Anemia	Dizziness	High Blood Pressure	Rheumatic Fever
Arthritis	Epilepsy	HIV / Aids	Tuberculosis
Asthma or Hayfever	Hepatitis/Liver problems	Kidney problems	Tumor or Cancer
Bone Disorders	Heart Problems	Nervous Disorders	Joint Replacement
Congenital Heart Defect	Heart Murmur	Prolonged Bleeding	

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

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 Have there been any injuries to face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
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 Have you ever been told that you grind your teeth? _____

OFFICE POLICIES

FEES - The fee for your treatment is based on the complexity of your case. You will be informed of the fee after your examination.

PAYMENT – It is our policy that payment for all services rendered be made in full AT or BEFORE the completion of treatment. We realize that some dental treatment may be of an emergency nature, and that patients may not always be prepared for unexpected dental expenses. To assist you in this regard, we gladly accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT.

DENTAL INSURANCE – If you believe that your treatment is covered by a dental insurance policy, we will be happy to complete the necessary forms. Please understand that while this is done for your convenience, most insurance plans do not cover 100% of the cost of treatment. You are expected to pay your deductible and your portion of the estimated charges the day the services are rendered. We will ESTIMATE as your coverage as closely as possible, but until we actually receive payment from the insurance company **it is just an estimate**. **We consider each patient to be responsible for their entire balance regardless of their insurance coverage.**

MISSED APPOINTMENTS – Confirmed appointments require 24 hour notice if you are unable to be present. You will be assessed a MISSED APPOINTMENT FEE ($25 for Each Appointment)

X _____ _____