

# PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Soc. Security # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Cellular # \_\_\_\_\_

Zip Code \_\_\_\_\_  Male  Female

Birth Date \_\_\_\_\_

Email \_\_\_\_\_  Single  Married  Separated  Divorced  Widowed

Employer / School \_\_\_\_\_

Phone \_\_\_\_\_

Street \_\_\_\_\_

Position \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Person Responsible For Account \_\_\_\_\_ Phone \_\_\_\_\_

Address If Different \_\_\_\_\_ Position \_\_\_\_\_

In Case Of Emergency Notify \_\_\_\_\_ Phone \_\_\_\_\_

Name Of Spouse \_\_\_\_\_

Birth Date \_\_\_\_\_

Employer \_\_\_\_\_

Phone \_\_\_\_\_

Street \_\_\_\_\_

Position \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

## If Patient is Child

Father's Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Employer \_\_\_\_\_

Phone \_\_\_\_\_

Street \_\_\_\_\_

Position \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Mother's Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Employer \_\_\_\_\_

Phone \_\_\_\_\_

Street \_\_\_\_\_

Position \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Do You Have Dental Insurance?  Yes  No

Whom May We Thank For Referring You To Our Office? \_\_\_\_\_

Please List Other Family Members Seen In This Office \_\_\_\_\_

## Optional Information To Help The Doctor Get To Know You:

Your Special Interests/Hobbies \_\_\_\_\_

Do You Have A Nickname? \_\_\_\_\_

How Long Have You Lived In Area? \_\_\_\_\_

## Dental History

Reason for today's visit: \_\_\_\_\_  
Former Dentist: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date of last dental visit: \_\_\_\_\_ Date of last dental X-rays: \_\_\_\_\_

Check (X) if you have had any of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding Teeth                | <input type="checkbox"/> Sensitivity To Heat           |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose Teeth Or Broken Filling | <input type="checkbox"/> Sensitivity To Sweets         |
| <input type="checkbox"/> Clicking or Popping Jaw       | <input type="checkbox"/> Periodontal Treatment         | <input type="checkbox"/> Sensitivity When Biting       |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sensitivity To Cold           | <input type="checkbox"/> Sores Of Growth In Your Mouth |
| <input type="checkbox"/> Stained Teeth                 | <input type="checkbox"/> Uneven/chipped Teeth          |  |

How often do you floss: \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## Medical History

Physician's Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No

If yes, describe: \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates: \_\_\_\_\_

(Women) Are you pregnant or think you might be pregnant?  Yes  No Nursing?  Yes  No

(Women) Are you taking birth control pills?  Yes  No

Do you have or had:

- | Y/No   | Y/No  | Y/No   | Y/No  |
|--|---|--|---|
| <input type="checkbox"/> AIDS                          | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever          |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Cough Up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness Of Breath    |
| <input type="checkbox"/> Artificial Heart Valves       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash              |
| <input type="checkbox"/> Artificial Joints             | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling Of Feet/ankle |
| <input type="checkbox"/> Back Problems                 | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problem        |
| <input type="checkbox"/> Blood Disease                 | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit          |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis            |
| <input type="checkbox"/> Chemical Dependency           | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Chemotherapy                  | Describe: _____                               | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                  |
| <input type="checkbox"/> Circulatory Problems          | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease       |
| <input type="checkbox"/> Used Phen-fen Diet Medication |   |  |   |

## Medications

List medications (prescribed/etc) you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Allergies

List any allergies (medications/food/latex...)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor \_\_\_\_\_

Date \_\_\_\_\_

Our office requires a 24 hour notice to cancel an appointment. If you do not show up for your appointment or do not call us at least 24 hours ahead of your appointment to cancel, you will be charged \$25.00.

As a courtesy, we will be happy to bill your dental insurance. It is very important that you have **ALL** the information below plus a **SIGNED AND COMPLETED INSURANCE FORM**.

Without this information, or incorrect information, we will **NOT** be able to process your claim. You will be required to **PAY IN FULL AT EACH APPOINTMENT**.

**SELF/FATHER**

**SPOUSE/MOTHER**

|   |       |       |
|---|-------|-------|
| Employee Who Has Insurance                | _____ | _____ |
| Social Security #                         | _____ | _____ |
| Name of Insurance Company                 | _____ | _____ |
| Address of Ins. Co.<br>(Required to Mail) | _____ | _____ |
|   | _____ | _____ |
| Group/Policy #                            | _____ | _____ |
| Union Local #                             | _____ | _____ |
| Employee #                                | _____ | _____ |
| Birthdate                                 | _____ | _____ |
| Any Additional Information                | _____ | _____ |
|   | _____ | _____ |

**OTHER**

|   |       |
|---|-------|
| Employee Who Has Insurance                | _____ |
| Social Security #                         | _____ |
| Name of Insurance Company                 | _____ |
| Address of Ins. Co.<br>(Required to Mail) | _____ |
|   | _____ |
| Group/Policy #                            | _____ |
| Union Local #                             | _____ |
| Employee #                                | _____ |
| Birthdate                                 | _____ |
| Any Additional Information                | _____ |
|   | _____ |

To obtain dental insurance benefits, it may be required to submit the Doctor's treatment plan to the insurance company(s) for a "Pre-determination" of benefits or in some cases, obtaining the information by phone. We can **NEVER** guarantee payment by your insurance company. The insurance company's contract is with you and your employer.

The patient/guardian agrees to be and is fully responsible for total payment of services performed in this office including any amounts not covered by any dental/medical insurance or prepayment programs the responsible party(s) may have.

Patient's Signature or Parent's Signature if a Minor \_\_\_\_\_ Date \_\_\_\_\_

Financial arrangements are both necessary and beneficial in maintaining a sound professional relationship which ultimately benefits every one involved.

We wish to inform you of our office policy in this regard.

1. On the initial visit for examination, consultation, x-rays and prophylaxis or emergency treatment, the charges are payable at that visit. For those patients with dental insurance, you will be responsible for the share your insurance company won't cover at that visit.
2. At each consecutive visit, you will be responsible for all charges at each visit. For those with dental insurance, you will be responsible for the patient share, at time of scheduling.
3. You may use your VISA, MASTER CARD, AMERICAN EXPRESS or DISCOVER.
4. If necessary, other financial options are available.
5. If a check is returned to us by the bank for any reason, a \$30.00 return check charge will be added to the amount issued.
6. We need to precollect patient portion prior to scheduling appointments with all the doctors.

### **FOR PATIENTS WITH INSURANCE**

We will bill your insurance company for you.

At each visit, we will give you an estimate of what your insurance company will pay for each procedure. Keep in mind that it is an ESTIMATE, and sometimes insurance companies pay on a lower fee schedule. In that event, you will be responsible for what the insurance company didn't cover.

In the event your records or x-rays need to be duplicated and transferred to another office, they will be subject to a \$31.00 fee.

Name \_\_\_\_\_ Date \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Office Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date