Hart & Coco
PROSTHODONTICS
DENTAL RECONSTRUCTION • TMJ THERAPY • DENTURES
DENTAL IMPLANTS • BRIDGES • CROWNS • VENEERS

PATIENT INFORMATION

Name____Date___________________ ☐ Male ☐ Female
Address____City______________________State_________Zip____________________
SSN____ DOB____
Home Phone _______________________________________Cell Phone____
E-mail ____
Employer____Work Phone________________________________
Employer Address________________________________City_________________________State____________Zip___________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner
How did you hear about our office? ____
Person to contact in case of emergency__________________________________Phone __________________________________

RESPONSBILE PARTY

Name of Person
Responsible for this Account__________________________________ Relation to Patient___________________________________
Address____ Home Phone_______________________________________
DOB____Bank____
Employer____Work Phone______________________________________
E-mail____ Cell Phone_________________________________ _________

DENTAL INSURANCE

Subscriber Name______________________Relationship to Patient:________________Subscriber DOB______________________
Subscriber SSN/ID____Subscriber Employer ______________________________
Insurance Company Name:____
Insurance Company Address:____
Insurance Company Phone:________________________Group Number:____

MEDICAL INSURANCE

Subscriber Name______________________Relationship to Patient:________________Subscriber DOB______________________
Subscriber SSN/ID____ Subscriber Employer ______________________________
Insurance Company Name:____
Insurance Company Address:____
Insurance Company Phone:________________________Group Number:____

DENTAL HISTORY

Current Dentist____City________________________________State________
Date of Last Visit________________________________Reason for Visit____
Check (√) if you have had problems with any of the following:

☐ Grinding Teeth ☐ Loose Teeth or broken fillings ☐ Bleeding gums ☐ Clicking or popping jaw
☐ Periodontal treatment ☐ Food collection between the teeth ☐ Sensitivity to cold ☐ Jaw pain
☐ Sensitivity when biting ☐ Sores or growths in your mouth ☐ Sensitivity to hot

MEDICAL HISTORY

Physician Information: Are you under a physician's care at present? Yes __________ No__________

Name: ____

Address: ____ Phone: ____________________________________

Have you been to other physicians during the last two years? Yes __________ No___________

What are these physician's names, addresses, and telephone numbers?

____

____

Do you have any of the following allergies (please list specifics, where applicable):

Analgesics or pain medications? Yes __________ No __________

Antibiotics, for example Penicillin or Erythromycin? Yes __________ No __________

Latex or Rubber Products? Yes __________ No __________

Metals? Yes __________ No __________

Any dental materials (for example, resins, nickel, amalgam, etc.)? Yes __________ No __________

Other allergy not listed above, please specify: ____

____

Hospitalization and past surgery information:

Have you ever been hospitalized? Yes __________ No __________

Have you ever had surgery, including eye surgery? Yes __________ No __________

Did you have a bad result or a peculiar reaction to a general anesthetic, medicine, or injection? Yes __________ No __________

Have you ever received a blood transfusion or blood product (e.g. plasma)? Yes _________ No __________

Drugs or medications you are taking:

Are you taking any medications or drugs on a regular basis? Yes __________ No __________

Please list:____

____

Are you taking any herbs and/or over-the-counter medications? Yes __________ No __________

Are you taking blood thinner medications? Yes __________ No __________

Have you ever received or taken steroid medication such as cortisone or body building steroids? Yes __________ No __________

Have you been treated for, or received any of the following:

Weight loss medications? Yes __________ No __________

Have you taken Fen-Phen, Redux, or Pondimin diet pills? Yes __________ No __________

Cancer? Yes __________ No __________

Radiation treatment? Yes __________ No __________

Chemotherapy? Yes __________ No __________

An injury to your face or jaws? Yes __________ No __________

Treatment for drug or alcohol dependence? Yes __________ No __________

Treatment for osteoporosis or taken bisphosphonates? (e.g. Fosamax, Boniva) Yes __________ No __________

Do you fear dental treatment? Yes __________ No __________

Have you had x-rays within the last year? Yes __________ No __________

Do you have or have you ever had any of the following:

Heart trouble of any kind	Yes	No	Hypoglycemia or low blood sugar	Yes	No
Mitral valve prolapse	Yes	No	Hepatitis or liver disease	Yes	No
Heart valve defects/surgery	Yes	No	A sexually transmitted or venereal disease	Yes	No
Heart bypass/angioplasty/stent	Yes	No	An infectious or communicable disease	Yes	No
Heart pacemaker/defibrillator	Yes	No	HIV positive or AIDS	Yes	No
Enlarged heart or congestive heart failure	Yes	No	An endocrine disorder, such as thyroid disease	Yes	No
Rheumatic fever	Yes	No	Immune system suppression	Yes	No
Heart murmur	Yes	No	Systemic lupus erythematosus (SLE)	Yes	No
Angina	Yes	No	Multiple Sclerosis	Yes	No
Heart attack	Yes	No	A bone, muscle, or joint disorder, such as arthritis	Yes	No
Chest pain	Yes	No	Artificial joint/bone replacement	Yes	No
Endocarditis	Yes	No	Transplanted organ	Yes	No
Spleen removal	Yes	No	Parkinson's disease	Yes	No
Stroke	Yes	No	Anxiety or depression	Yes	No
Blood vessel or cerebral fluid shunt	Yes	No	Psychological disorder?	Yes	No
Implant/graft of artery or vein	Yes	No	Alzheimer's disease or dementia	Yes	No
Difficulty breathing	Yes	No	Dry mouth or xerostomia	Yes	No
High blood pressure	Yes	No	Anorexia, bulimia, or eating disorder	Yes	No
Low blood pressure	Yes	No	Ulcers	Yes	No
Hemophilia	Yes	No	Tuberculosis	Yes	No
Excessive bleeding	Yes	No	Mononucleosis	Yes	No
Anemia	Yes	No	Birth defect or hereditary disease	Yes	No
Blood disorder	Yes	No	Any medical condition not listed above ______________________________ ______________________________		
Sickle cell disease	Yes	No			
Sickle cell trait	Yes	No			
Emphysema or chronic bronchitis	Yes	No			
Asthma	Yes	No			
Seizures, convulsions or epilepsy	Yes	No			
Kidney dialysis	Yes	No			
Diabetes	Yes	No			

Do you use tobacco products in any form? Yes __________ No __________

If so, please circle which of the following:

Cigarettes Cigars Dip Chew Pipe

If you use tobacco, are you interested in quitting? Yes __________ No__________

<u>Female Patients</u>:

Are you pregnant? Yes __________ No __________

Are you unsure? Yes __________ No __________

Are you nursing? Yes __________ No __________

Are you taking birth control pills? Yes __________ No __________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health. Patient signature____ Date _________________

FINANCIAL RESPONSIBILITY

Many patients have a commonly held misconception that medical and dental benefit policies that their employers or they have individually purchased will pay for all of their treatment. THAT IS INCORRECT AND UNTRUE.

As a patient in this office, you will receive treatment that is specific to the problems that are noted during your examination. Your doctor will carefully review his/her findings with you and explain to you the treatment options (if any) that are available to you. In return, your financial responsibility for the treatment that you agree to will be to the doctor's office. We will be glad to assist you in obtaining reimbursement for part of these benefits from your medical and/or dental insurer.

Often insurance companies, upon the patient's request, will send benefit reimbursement directly to the doctor's office. Please understand that your benefits contract will always have an allowable benefit payment for each procedure performed and that allowable benefit is determined by the limitations of the contract that your employer or you personally have purchased from the insurer and does NOT always equal the doctor's submitted fee. Your insurance plan will pay only a percentage of the allowable benefit your employer or you have bought as part of your plan with a co-payment portion being assigned to you. You are responsible to your doctor for payment of your yearly deductible (if not already satisfied), the patient co-payment portion, and any remaining portion of your doctor's bill that is not covered by your insurance plan.

We will be happy to discuss with you financial arrangements for the payment of your bill whether or not you have medical/dental insurance available to you. Please understand that third party payment is NOT a guarantee of benefits payment even though you may feel that you have the coverage under your insurance policy(ies). Financial responsibility for all services received at this office is yours alone. We will gladly work with you to arrange payment for services provided, and these arrangements will be set up on an individual-needs basis.

AUTHORIZATION AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage ________________________and assign directly to
Name of Insurance Co(s)
Dr. ____________________ all insurance benefits (if any) otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions. I also understand that if a collection agency is required to recover any unpaid balances on my account, the signee is liable for all collection agency fees incurred.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

__________________________ ____ Date: ______________________
(Signature of Patient, Parent, Guardian or Personal Representative)

_______________ ____ Relationship: ___________________________
(Print Patient, Parent, Guardian or Personal Representative)

Thank you for your confidence in our office and our doctors. We look forward to providing you with competent care and courteous service.