Cosmetic & Preventive Dentistry

Patient Information

Patient Name: _____ Birth Date: _____
Last, First MI (Preferred Name)

Address: _____ Marital Status: _____
Street City State Zip Code

Social Security Number: _____ Driver 's License Number: _____

Phone (Home): _____ (Work w/Ext.): _____ (Mobile): _____

Appointment reminders via text? Yes / No (circle one) Email Address: _____

How did you hear about our practice? _____

Insurance Information – Please supply ID card(s)

Primary

Insurance Plan Name and Address: _____ Social Security Number _____

Insured's Employer Name: _____

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Full-time Student Status: Yes or No *(circle one)*

Name of School_____

Secondary

Insurance Plan Name and Address: _____

Insured's Employer Name: _____

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Please indicate which family member billing statements should be addressed to: _____

Payment and Appointment Policy

Payment is due at time of treatment unless financial arrangements have been approved in advance. We work with insurance companies to process claims and estimate coverage as a courtesy to our patients who carry dental insurance. Patient is fully responsible for balance regardless of insurance coverage. Please notify us of appointment changes or cancellations as far in advance as possible. Appointments cancelled or changed less than twenty four hours in advance or missed appointments will result in a $75.00 cancellation fee.

_____ *Date:* _____
Signature of patient, parent or guardian

Acknowledgement of Receipt of Notice of Privacy Practices

_____ *have received a copy of this office's Notice of Privacy Practices.*
Please Print Name

_____ *Date:* _____
Signature of patient, parent or guardian

Cosmetic & Preventive Dentistry

*Patient Name:*_____

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bacterial Endocarditis
- ☐ Cancer
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Transplant
- ☐ Heart Valve Replacement
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Nervous Disorder
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Smoking History
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy

Other:

- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician for a specific illness? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any medical conditions, artificial joints or heart problems that would require pre-medication?_____
- Please list all medications that you are currently taking (including over the counter) _____

_____

_____

- Please provide your Health Care Aid's name and telephone number _____
- Have you travelled to: Liberia, Sierra Leone or Guinea in the last 21 days? ☐ No ☐ Yes

  If yes, please let us know when you arrived into the U.S.? Month_____ Day_____
- Are you feeling feverish? ☐ No ☐ Yes

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian