PATIENT PERSONAL HISTORY

Legal Name:		What would you prefer to be called?	
Birthdate:	Email:	Spouse Name (if applicable)	
Mailing Address:			Gender:
City, State, Zip:		Social Security #:	
Home Phone:		Cell Phone:	
Employer:		Work Phone:	
What is the best number to contact you? Home Cell Work			May we text you? Yes No

How did you hear about our office?		Drive-By/Sign	Internet (which site?)	
Coal City Courant	Free Press News	Morris Daily Herald	Dwight Paper	Phone Book
Family/Friend (Name Optional):			Other:	

Emergency Contact:	Phone:	Relationship:

When are the best times for you to come in for appointments?				**OR circle one:**
Mon: (9am-6pm)	Tues: (9am-5pm)	Wed:(12pm-8pm)	Sat: (9am-5pm)	Any Time
____:____-____:____	____:____-____:____	____:____-____:____	____:____-____:____	Schedule Varies

INSURANCE INFORMATION

Primary Dental Ins: __________	Secondary Dental Ins: __________
Policyholder Name: __________	Policyholder Name: __________
Policyholder DOB: __________	Policyholder DOB: __________
Policyholder Employer: __________	Policyholder Employer: __________
Policyholder SS#: __________	Policyholder SS#: __________
Subscriber ID#: __________	Subscriber ID#: __________
Policy / Group #: __________	Policy / Group #: __________
Phone Number:	Phone Number:

By signing below, I affirm that I give my permission to Dr. Trevison and/or her associates for dental evaluation, x-rays, and treatment, and that I am the financially responsible adult on this account.
(If under 18 years of age, a financially responsible adult MUST sign!)

______________________________ ________________

Signature Date

____________________ ________________ ____________

Print Name SS# (If not patient) Relationship to Pt

PATIENT DENTAL HISTORY

Last dental visit:	Previous dentist name/location:
What brings you to our office today?	
Are you fearful of dentistry?	
Is there anything you would like to change about your smile?	
Are your teeth sensitive to hot, cold, pressure?	
Does food catch between your teeth?	
Have your teeth shifted/loosened?	
Do you clench or grind your teeth?	
How often do you floss your teeth?	
Do your gums bleed?	
Have you been told you have periodontal (gum) disease? No Yes:	
Do you have clicking/popping in you jaw/ear area? No Yes: (which side)	
Do you have pain in your jaw?	
Do you have any sores, growths, bumps in your mouth?	
Have you had complications from dental treatment?	

PATIENT MEDICAL HISTORY

Physician's Name/Location:	Phone Number:
When did you last see your medical doctor?	
Cardiologist/other specialist information:	
Do you smoke? No Yes (how much?):	
Do you chew tobacco? No Yes (how much?)	
Pharmacy Name/Location:	Pharmacy Phone:

List ALL medications/supplements you are currently taking **(If NONE, please note):**

Medication Name	**Dosage**	**Condition/Indication**

Write "Yes" or "No" on each line/circle which applies; If you answer yes, PLEASE EXPLAIN.	
Abnormal Bleeding?	Heart Attack?
Anemia?	Endocarditis or Angina?
Allergies/Sinus Problems?	Pacemaker?
Asthma?	Congenital Heart Disease?
Arthritis/Rheumatism?	Congestive Heart Failure?
Artificial Joints?	Artificial Heart Valve?
Cancer?	Other Heart Problems?
Chemotherapy/Radiation?	Psychiatric Disorders?
COPD/Emphysema?	Depression?
Diabetes?	Stroke?
Drug/Alcohol Abuse?	Tuberculosis?
Epilepsy/Seizures?	Taken Fosomax/Boniva/Actonel (Bisphosphonate) for osteopenia/osteoporosis?
Gastritis/Colitis/Ulcers?	
Hepatitis/Liver Disease?	**Do you pre-medicate** (take antibiotics) before appointments?
High Blood Pressure?	
HIV/AIDS/HPV?	**Any other medical conditions?**
Kidney/Liver Problems?	

Are you allergic to any of the following?	**(Write yes or no on EACH line please)**	
Aspirin?	Latex?	Metals? (type)
Codeine?	Dental Anesthetics?	**Any other allergies?**
Penicillin?	Erythromycin?	

Have you had any major operations in the past 5 years? **If yes, please note surgery and YEAR.**
No Yes:
WOMEN ONLY: Could you be pregnant? No Yes Are you currently nursing? No Yes

Sign below to affirm the above information is accurate and you will inform us of any changes as soon as posible.

Signature: ________________________________ Date: ________________________________

OFFICE USE: BP:_________/_________ Reviewed history ______/______/______; Dr.____________________________

Coal City Dental Center Office Policies

_____ Regular six month or minimum of one year checkup appointments are required to be considered an established patient. Note this includes x-rays to be taken as needed.

_____ ALL **ESTIMATED** co-payments are due on date of service if you have insurance, or payment in full if no insurance. We will accept any PPO insurance as in or out-of-network, but coverage may vary depending on network status. We will contact your insurance to verify coverage, however their policy states that if the information we are given is incorrect, the contract you signed will prevail. Please note that we do not accept payment from Workman's Compensation, Litigated Settlements, or any other 3rd party payor other than insurance unless it is paid on the date of service.

_______ **UNDER AGE 18:** If not accompanied by an adult, payment is still required. A financially responsible adult must sign initial paperwork and should be present at the appointments. If this is not possible, this will need to be discussed with Coal City Dental PRIOR to the appointment.

_______ If no notice or less than 24 hours notice is given, an automated charge of $25 will be assessed, and payment of this fee will be required before scheduling another appointment. If notice is given, the fee may be waived. If you are more than 10 minutes late, you may be asked to reschedule and may be billed this fee. If 2 appointments are broken with insufficient notice, you may be dismissed.

_______ If your account balance remains unpaid beyond 90 days, it will be submitted plus a 33% fee to a collection agency. This amount will also include reversal of any courtesy discounts. You will also need to find a new dentist. If you are welcomed return following collection or bankruptcy, you must pay in full.

_______ If you do not wish to give your social security number, this is not required, however you may be asked to pay in full for all treatment.

Sign below to indicate that you understand and agree to the above policies, and are the financially responsible adult on this account:

Signature: ________________________________Date: ___________Relation to pt: _____________

Print Name: ____________________________ Birthdate: ______________ SS#: _______________

Notice of Privacy of Practices Acknowledgment

I have received, read and understand Coal City Dental Center's NOTICE OF PRIVACY PRACTICES. I understand I have the right to refuse to sign. (These are posted in our waiting room and a copy is available to you.)

Signature: ______________________ **Date:** ______________

Print Name: ______________________ Relationship to Patient: ______________

CONTACT DETAILS:

We can email your x-rays/information to specialists that we may refer you to. These e-mails are unencrypted, and could be viewed by others if intercepted.

_______ **YES**, please send my x-rays electronically. (Note: This consent may be revoked at any time.)

_______ **NO**, please send printed copies of x-rays only by mail or with to the appointment.

YES NO May we leave **detailed** phone messages at your home/cell?

We may text regarding appointments. Yes No	We may e-mail regarding appointments. Yes No
We may call/mail regarding appointments. Yes No	We may e-mail promotions/newsletters. Yes No
We may call/mail regarding your account. Yes No *If you disallow this contact, you must pay in full for appts	*Unless declined, we may use all contact methods-If you decline any contacts, a down-payment is required to hold an appointment.

Do you request a more confidential notification regarding appointments? No Yes

May we use your name to call you from the waiting room into the treatment room? No Yes

Please print all the names you allow information given to or received from:

Name ______________________ Relationship ______________

Name ______________________ Relationship ______________

For Office Use Only:

Attempt to obtain the patient's signature of receipt of the notice of privacy practices was unsuccessful:

Reason:	Initials:	Date: