PATIENT INFORMATION FORM

LAST NAME: _____ TITLE: _____ FIRST NAME: _____

MIDDLE NAME: _____ NICK NAME: _____

HOME ADDRESS: (IF P0 BOX GIVE STREET ALSO) _____ CITY: _____

HOME PHONE: _____ WORK PHONE: _____ **CELL PHONE**: _____

E-MAIL: _____

DOB: ____ / ____ / ____ MARITAL STATUS: _____ SEX: _____ SS#: _____

EMPLOYER NAME AND ADDRESS: _____

REFERRED BY: _____

THE NAME OF THE LAST DENTIST YOU SAW AND HOW LONG AGO: _____

Four Questions to be Answered if age 14 or older:

1. **Are you happy with the appearance of your teeth/gums/smile? Yes No**

2. **.What don't you like about your smile?**

_____

_____

3. **Would you like to discuss enhancing the appearance of your smile? Yes No**

4. **Would you like to discuss how to make your teeth white? Yes No**

PRIMARY INSURANCE COVERAGE

SUBSCRIBER'S NAME AND ADDRESS: _____
RELATION TO PATIENT: _____ SS#: _____-_____-_____ DOB: ____/____/____
EMPLOYER NAME AND ADDRESS: _____
INSURANCE COMPANY NAME AND ADDRESS: _____
_____
GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV. YRLY DEDUCT: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER'S NAME AND ADDRESS: _____
RELATION TO PATIENT: _____ SS#: _____-_____-_____ DOB: ____/____/____
EMPLOYER NAME AND ADDRESS: _____
INSURANCE CO. NAME AND ADDRESS: _____
_____
GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV. YRLY DEDUCT: _____

RESPONSIBLE PARTY FOR PATIENT:

A. SERVICE CHARGE:

If I do not pay the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum of $6 for a balance under $280) which is an annual percentage rate of 18% applied to the last month's balance In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred, to effect collection of this account or future outstanding accounts.

B. DENTAL INSURANCE:

I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the dentist. Therefore, I am still responsible for all cost of dental treatment. I hereby authorize payment directly to the dental office of my insurance benefits otherwise payable to me. I understand that the dental office tries to estimate what portion of treatment is my responsibility at each visit. Again, I understand this is only an estimate, and I am responsible for all dental fees. If for any reason insurance has not paid in 45 days, the full balance is automatically turned over to me for payment.

NAME AND ADDRESS (responsible party): _____
DRIVERS LICENSE #: _____ DOB: ____/____/____ SSN#: _____/_____/_____

SIGNATURE: (RESPONSIBLE PARTY)_____

CONFIDENTIAL MEDICAL HISTORY FORM

MEDICAL ALERTS: _____
Physician's Name: _____Telephone #: (___)_____
Date of Last Physical Exam: _____
Are you now or have you recently been under a physician's care? _YES _NO
Reason: _____
Have you ever been a patient in a hospital or had any serious illness?
Explain: _____

Circle yes or no to any of the following that you have had or suspected you have had:

Yes No: Arthritis
Yes No: Rheumatic Fever
Yes No: Heart Trouble/ or Pacemaker
Yes No: Heart Murmur/Mitral Valve Prolapse
Yes No: High/Low Blood Pressure
Yes No: Chest Pain
Yes No: Heart Attack/Stroke
Yes No: Shortness of Breath
Yes No: Asthma or Hay Fever
Yes No: Prosthetic Valve/Joint Replacement

Yes No: Hepatitis or Jaundice
Yes No: Liver Disease
Yes No: Cancer/Chemotherapy
Yes No: Tuberculosis
Yes No: Diabetes
Yes No: Kidney/Bladder Trouble
Yes No: Anemia/Blood Disease
Yes No: Lung Disease
Yes No: Drug/Alcohol Abuse
Yes No: Severe/Frequent Headaches

Yes No: Prolonged Bleeding
Yes No: Fainting Tendency
Yes No: Epilepsy/Seizures
Yes No: Thyroid Disease
Yes No: Glaucoma
Yes No: Radiation Treatment
Yes No: Mental Disorders
Yes No: HIV or AIDS
Yes No: Sinus Trouble
Yes No: Blood Transfusion

Check any of the following that you are taking or have taken:

_Cortisone Drugs _Anticoagulants _Tranquilizers ___Biphosphonate Drugs (For Osteoporosis, Bone metastases,
_Steroids _Blood Thinners _Sedatives or Pagets Disease; such as but not limited to Fosamax, Actonel, Bonita, Aredia, Zometa, Didronel, or Skelid)

Are you taking any other medication? _YES _NO. If yes, explain: _____
_____

Are you allergic to or do you suffer ill effects from any of the following:

_Penicillin _Codeine _Dental Anesthesia _any metal or jewelry
_Aspirin _Latex Material _**OTHER:**

WOMEN ONLY: Are you Pregnant? _YES _NO
If yes: How many months?_ Are you breast feeding? _____
Are you presently taking medicine of any kind routinely? (Birth control pills, shots, implants, or hormone therapy, etc.) Explain: _____
_____.
_____

I understand the information I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I also understand that dentistry is not an exact science, and there are some inherent risks associated with any dental procedure, such as, but not limited to, the small risk of dental paresthesia associated with a dental injection or an allergic reaction, etc. I authorize the dental staff to perform any dental service with my informed consent that I may need during diagnoses and treatment.

I understand if I am unable to keep a scheduled appointment that a 48-hour notice is required. If this notice is given there will be absolutely no charge. However, if 48-hour notice is not given a $40 fee per 30-minute appointment time will be charged to my account.

_____ **Date**_____
Patient (or guardian) Signature

Reviewed with patient by_____ Date_____ ;_____ Date_____ ;_____ Date_____ ;_____ Date_____ ;Date_____ ;_____

_;_____ Date_____;_____ Date_____;_____ Date_____