

Patient Information

Date : _____

Name (Last): _____

Name (First, MI): _____

Sex: _____ Email: _____

Birth Date: _____ SS# _____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance and other information

Primary Insured Name: _____

Birth Date: _____ SS# _____

Relationship to Patient: _____

Employer: _____

Insurance Company: _____

Group# _____ ID# _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____ Ph# _____

Financial / Insurance Filing Policy / Notice of privacy practices**1. Financial Responsibility:**

Payment is expected at the time of service. A missed appointment or late cancellation fee of \$25 will be assessed for notice less than 24 hours.

(If we are not filing insurance on your behalf, please skip item #2, and continue with #3)

2. I understand and certify that I have effective insurance coverage with:

_____ (insurance company name) _____ (Plan Group/ID)

- Patient Portion: We will collect "patient portion" on the day of service. Patient portion amount is an estimate based on Non-Binding information gathered from your insurance. Ultimately, patient is responsible for any amount that insurance does not cover. If the total payment received (from insurance and patient) exceeds the treatment fee, we will refund patient the difference.
- Filing Policy: As a courtesy, we will file your insurance for you for services rendered at our office. We will allow 30 days for insurance payment to your account. After 30 days, we will send you a statement requesting for any balance on your account.
- Financial Responsibility: **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FROM SERVICES RENDERED, WHETHER OR NOT PAID BY THE INSURANCE.**

3. I acknowledge that I have received a copy of the Notice of Privacy Practices

By signing below, I acknowledge I have read, understood and agree to the above policy.

Patient Signature (if minor, guardian signature)

Print Name of Signer

Date

How did you hear about us? Please check ones that apply:

___ Insurance provider list ___ Drive-by ___ Newsletters ___ Yellowbook ___ Website ___ other _____

___ Friend/colleague/relative Whom can we thank for this referral: _____

Dental History

Reason for today's visit: _____ _____ Former dentist: _____ City/State: _____ Date of last dental visit: _____ Date of last dental x-rays: _____ How often do you floss? _____ How often do you brush your teeth? _____	Please circle yes or no for the following: Bleeding gums? Yes / No Blisters on the lips or mouth? Yes / No Chew on one side of mouth? Yes / No Cigarette/Pipe/Cigar Smoker? Yes / No Clicking or popping jaw? Yes / No Dry mouth? Yes / No Food collection between teeth? Yes / No Grind/clench your teeth? Yes / No Gums swollen or tender? Yes / No	Jaw pain/tiredness? Yes / No Bite your lips/cheeks? Yes / No Broken fillings/ Loose teeth? Yes / No Mouth pain when brushing? Yes / No Orthodontic treatment? Yes / No Pain around ear? Yes / No Periodontal treatment? Yes / No Sensitivity to hot, cold or sweets? Yes / No Sensitivity when biting? Yes / No Sores/growths in your mouth? Yes / No
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Health History

Physician's Name: _____ Date of last visit: _____

**Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) Yes / No

Please circle yes or no to indicate if you have had any of the following: AIDS/HIV Yes / No Anemia Yes / No Arthritis/Rheumatism Yes / No Artificial heart valves Yes / No Artificial joints Yes / No Asthma Yes / No Back problems Yes / No Bleeding abnormally with extractions or surgery Yes / No Blood disease Yes / No Cancer Yes / No Chemical dependency Yes / No Chemotherapy Yes / No Circulatory problems Yes / No Congenital heart lesions Yes / No Cortisone treatments Yes / No Cough persistent or bloody Yes / No Diabetes Yes / No	Emphysema Yes / No Epilepsy Yes / No Fainting or dizziness Yes / No Glaucoma Yes / No Headaches Yes / No Heart murmur Yes / No Heart problems Yes / No Hepatitis Yes / No if yes, type? _____ Herpes Yes / No High blood pressure Yes / No Jaundice Yes / No Jaw pain Yes / No Kidney disease Yes / No Liver disease Yes / No Low blood pressure Yes / No Mitral Valve Prolapse Yes / No Nervous problems Yes / No Pacemaker Yes / No Psychiatric care Yes / No	Radiation treatment Yes / No Respiratory Disease Yes / No Rheumatic Fever Yes / No Scarlet Fever Yes / No Shortness of breath Yes / No Sinus trouble Yes / No Skin rash Yes / No if yes, when? _____ Special diet Yes / No Stroke Yes / No Swollen feet or ankles Yes / No Swollen neck glands Yes / No Thyroid problems Yes / No Tonsillitis Yes / No Tuberculosis Yes / No Tumor or growth on head or neck Yes / No Ulcer Yes / No Weight loss, unexplained Yes / No Do you wear contact lenses Yes / No
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FOR WOMEN
Are you pregnant? Yes / No If yes, when are you due? _____ Taking birth control pills? Yes / No Are you nursing? Yes / No

MEDICATIONS
List any medications you are currently taking and the correlating diagnosis: _____ _____ Pharmacy name: _____

ALLERGIES
Are you allergic to any of the following? Aspirin Yes / No Codeine Yes / No Iodine Yes / No Latex Yes / No Penicillin Yes / No Sulfa Yes / No Local Anesthetic Yes / No Barbiturates (sleeping pills) Yes / No Other?: _____

SIGNATURE REQUIRED: I certify that I have read this form in its entirety and acknowledge this information is correct to the best of my knowledge:	
_____ Signature	_____ Date