Patient Information

Date : _____

Name (Last): _____

Name (First, MI): _____

Sex: _____ Email: _____

Birth Date: _____ SS# _____

DL#_____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____ State:_____ Zip:_____

Insurance and other information

Primary Insured Name: _____

Birth Date: _____ SS#: _____

DL#_____

Relationship to Patient: _____

Employer: _____

Employer Phone #:_____

Insurance Company: _____

Group#: _____ ID#: _____

*********IN CASE OF EMERGENCY, CONTACT:**

Name _____

Relationship _____Ph#_____

Financial / Insurance Filing / Notice of Privacy Practices / Cancellation Policy

1. **Financial Responsibility:** Payment is expected at the time of service.
2. I acknowledge that I have read and/or received a copy of the "Notice of Privacy Practices"
3. I acknowledge that I have read and/or received a copy of "Appointment Cancellation Policy"
4. If a patient is younger than 18 years old, a PARENT OR LEGAL GUARDIAN MUST BE PRESENT DURING THE WHOLE APPOINTMENT for us to explain the procedures and to sign the required consents. The patient will not be seen if a parent or legal guardian is not present.
5. If you are more than **10 minutes** late to your appointment it will be canceled and counted as a missed appointment.

(If we are not filing insurance on your behalf, please skip item #6)

6. **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. The 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 primary insurance (**our office does NOT file secondary insurance plans**) 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.
- **Insurance Update:** I understand that my insurance coverage may change from time to time; it is my responsibility to inform the office whenever there is an update or change.

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 ___ Yellow book ___ 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

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

Other: _____

_____

FOR WOMEN

Are you pregnant? Yes / No

If yes, when are you due? _____

OBGYN Name & Phone Number: _____

Taking birth control pills? Yes / No

Are you nursing? Yes / No

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: _____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Preferred Pharmacy Name & Phone Number:

_____

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