PATIENT INFORMATION

Mr. Miss Mrs. Ms.

Patient's full name _____ Today's Date _____

SS#_____ Birthdate _____ Age_____ Sex_____ Weight_____Ht. _____

Patient's address_____ City_____ State_____ Zip_____

Home phone #_____ Cell phone #_____ Work phone # _____

Whom may we thank for referring you to our office?_____

Person to contact in case of emergency_____ Phone_____

GUARANTOR//PARENT: ❑ Same as above

Guarantor/Parent Name _____ Relationship to patient _____

Address_____ City _____ State_____ Zip_____

Phone_____ Date of Birth _____ Social Security #_____

Employer_____ Employer Telephone_____

INSURANCE TO BILL:

❑ DHW/DQ _____ ❑ Medicaid #_____

❑ Private Insurance (**Complete lines below fully**):

Primary Insurance Name_____ ❑ Medical ❑ Dental

Subscriber's name_____ Relationship to patient_____

Subscriber's address_____

Social Security #_____ Group #_____ Date of Birth_____

Employer_____ Employer phone #_____

Secondary Insurance Name_____ ❑ Medical ❑ Dental

Subscriber's name_____ Relationship to patient_____

Subscriber's address_____

Social Security #_____ Group #_____ Date of Birth_____

Employer_____ Employer phone #_____

Our fees are due when services are rendered. If other arrangements are necessary, they need to be made before service is rendered. While we will assist you in filing insurance claims, the entire amount of our fees is the patient's responsibility. Any amount failed to pay or contested or denied by the insurance company is between the patient and the insurance company. As part of our analysis of your credit standing, we may request an investigative consumer credit report.

Any patient account unpaid after 60 days from the date of service may be charged interest at the rate of 1.5% per month. In case of failure to pay, we reserve the right to add additional costs like, but not limited to, reasonable collection fees, finance charges, late fees, court costs and attorney's fees. These costs are also the patient's responsibility. Thank you.

Signature of patient: _____

Signature of responsible party (parent/guardian/POA):_____

- PATIENT MEDICAL INFORMATION -

Please Circle
Yes or No

1. Has there been any change in your general health in the past year?..... Y N
2. My last physical examination was on _____
3. Are you now under the care of a physician?..... Y N
   a.) If so, what is the condition being treated. _____
4. Have you had any serious illness or operations?..... Y N
   a.) If so, what was the illness or operation. _____
5. Have you been hospitalized or had a serious illness within the past 5 years?..... Y N
6. Do you have or have you ever had any of the below diseases or problems?..... Y N

Sleep Apnea Rheumatic Fever Heart Disease Cardiovascular Disease Heart Attack High Blood Pressure Stroke

Asthma Seizures Diabetes Hepatitis Latex Allergy Stomach Ulcers Kidney Trouble Venereal Disease

Anemia Abnormal Bleeding Artificial Joints or Heart Valves Heart Murmur Mitral Valve Prolapse Tuberculosis

7. Do you have any disease, condition, or problem not listed above that you think we should know about?..... Y N
   _____
8. Do you have AIDS or have you tested positive for the AIDS virus?..... Y N
9. Do you take? Coumadin Plavix Aspirin Effient Xeralto Pradaxa Eliquis..... Y N
10. Are you taking any drugs or medicines?..... Y N
    If so, please list medications. _____
    _____
    _____
    _____
11. Are you allergic to any medications?..... Y N
12. Have you had any serious trouble associated with any previous dental treatment?..... Y N
13. Are you pregnant?..... Y N
14. Do you smoke?..... Y N
15. Have you ever had a problem with drug or substance abuse?..... Y N
    a.) If so, explain _____

Please complete the following:

PHYSICIAN: _____

DENTIST: _____

YOUR CURRENT PHARMACY: _____

REVIEWED BY: DR. _____

Form Updated _____ _____
Date / Initials _____ _____