PATIENT INFORMATION

Name ______________________ Social Security Number ______________________

Home Address ______________________ ______________________
(Apt. #) (Street) (City) (State) (Zip)

Occupation ______________________ Date of Birth ______________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Gender: Male __ Female ______ Referred by ______________________

Person Responsible For Account:

Name ______________________ Relationship to Patient ______________________

Address ______________________ ______________________
(Apt. #) (Street) (City) (State) (Zip)

Home Phone ____________ Work Phone ____________ Social Security Number ______________________

Person to Contact in case of Emergency:

Name ______________________ Relationship to Patient ______________________

Address ______________________ ______________________
(Apt. #) (Street) (City) (State) (Zip)

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Dental Insurance Information:

Primary Insurance carrier ______________________ I.D. # ______________________

Insured or Employee's Name ______________________ Date of Birth ______________________

Employer ______________ Group No. ______________ Effective Date ____________

We consider our relationship with you to be of primary importance. We will always make our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. As the patient, it is your responsibility to deal with your insurance company and your employer. We will file your claims and assist you in any way possible to maximize your dental insurance benefits, but we want to reemphasize that we are not participating providers with any insurance companies and that you are financially responsible for the fees charged in our office.

- □ I authorize the release of all necessary information to my insurance carrier
- □ I authorize payments directly to the provider
- □ I have read this form and agree to be financially responsible for all fees regardless of insurance coverage.

Financial Information

Dental Insurance. We will fill out and file insurance forms at no charge. You are responsible for the balance of the treatment fees not covered by insurance.

Payment Options. Visa. Master Card and Discover Card is accepted for your convenience. A monthly 1 1/2 % finance charge (18% annually) will be added to all unpaid balances over 90 days.

The undersigned agrees that the responsibility for payment of dental services rendered in this office for himself/herself or his/her dependents is his/hers. The undersigned also agrees that in the event of default of this Agreement, this office shall be entitled to recover all costs of collection including a reasonable fee for the services of an attorney.

____ ______________

(Patient) (Date)

____ ___________________________

(Parent/Guardian) (Relationship to Patient)

Notice of Privacy Practices

The privacy of your health information is important to us. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to provide you with a copy of our privacy practices, our legal duties, and your rights concerning your health information.

You may request a copy of our notice at any time. For more information about our privacy practices, or for a copy of our Notice of Privacy Practices, please contact our office.

I, ____ have been informed that I may obtain a copy of this office's Notice of Privacy Practices at any time.

____ ______________________

(Signature) (Date)

Office Hours

Monday – Friday 8:00 A.M. – 5:00 P.M. Lunch Hour 1:00 P.M.– 2:00 P.M.

We will make every effort to accommodate emergency patients.

Appointment Cancellation

We ask that you give us 24 hours notice if you are unable to keep an appointment, otherwise a charge will be made for the time reserved for you. We understand, and will make exceptions, if you have an emergency.

MEDICAL HISTORY

Please indicate any condition that you have had in the past or have now by circling YES or NO and fill in the blank space where indicated.

Primary physician's name ______________________________

Phone number ______________ Address ______________________

CARDIOVASCULAR

Heart Disease or Attack	YES	NO
Angina pectoria or chest pains	YES	NO
High blood pressure	YES	NO
Heart murmur or click	YES	NO
Mitral valve prolapse	YES	NO
Rheumatic fever	YES	NO
Congenital heart defect	YES	NO
Heart surgery/transplant	YES	NO
Artificial heart valve	YES	NO
Irregular heart beat/arrhythmia	YES	NO
Heart pacemaker/defibrillator	YES	NO
Other heart problem	YES	NO

HEMATOLOGIC

Blood transfusion	YES	NO
Anemia	YES	NO
Sickle cell(anemia) disease	YES	NO
Tendency to bleed long	YES	NO
Hemophilia	YES	NO
Leukemia	YES	NO

NEURAL

Stroke or transient ischemia attack	YES	NO
Severe headaches/migraines	YES	NO
Earaches/ringing in ears	YES	NO
Fainting/dizzy spells	YES	NO
Epilepsy, seizures, or convulsions	YES	NO
Nervousness	YES	NO
Psychiatric treatment	YES	NO

ENDOCRINE

Diabetes	YES	NO
Thyroid disease	YES	NO

DERMAL/ORAL/MUSCOLO-SKELETAL

Skin rash/hives	YES	NO
Arthritis/rheumatism/gout	YES	NO
Artificial joint	YES	NO
Fever blisters/canker sores	YES	NO

GASTROINTESTINAL

Stomach/intestinal ulcers	YES	NO
Gastritis or esophageal reflux	YES	NO
Hepatitis/yellow jaundice	YES	NO
Cirrhosis	YES	NO
Other liver problem	YES	NO

RESPIRATORY

Sinus trouble	YES	NO
Asthma	YES	NO
Persistent cough	YES	NO
Emphysema	YES	NO
Tuberculosis (TB)	YES	NO
Breathing difficulties	YES	NO

GENITO-URINARY

Kidney or bladder problems	YES	NO
Dialysis	YES	NO
STD (syphilis/gonorrhea/chlamydia, herpes)	YES	NO

OTHER CONDITIONS

Enlarged lymph node/gland	YES	NO
Persistent/unexplained fevers	YES	NO
HIV-positive/AIDS	YES	NO
Use tobacco	YES	NO
Use alcohol	YES	NO
Drug-addiction	YES	NO
Tumor or cancer	YES	NO
Radiation treatment	YES	NO
Chemotherapy	YES	NO

ALLERGIES

Are you allergic to:

_Latex or Rubber	YES	NO
_local anesthetics ("novocaine")	YES	NO
_penicillin or other antibiotics	YES	NO
_aspirin	YES	NO
_codeine or other pain medicine	YES	NO
_any other drug (list below)	YES	NO

____

____

____

Are you (or are you supposed to be) taking any medicine, drugs or pills of any kind? YES NO
If yes, please list the name and dosage of all medicines:

_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________

Have you ever been hospitalized?
If yes, please describe YES NO

____
____

DENTAL HISTORY

Do you make regular (non-emergency) visits to the dentist?	YES	NO
Do your teeth feel loose?	YES	NO
Do your gums bleed when you brush your teeth?	YES	NO
Are any of your teeth painful to biting or chewing?	YES	NO
Do you ever have pain, or experience clicking, popping or grinding when you open and close your mouth?	YES	NO
Do you grind or frequently clench your teeth?	YES	NO
Does your mouth frequently feel dry?	YES	NO
Have you ever worn braces?	YES	NO
Have you ever worn dentures?	YES	NO
Do you gag easily or gag during dental treatment?	YES	NO
Have you ever fainted or had a bad experience related to dental treatment?	YES	NO

WOMEN ONLY

Is there a possibility you may be pregnant?	YES	NO
Are you nursing?	YES	NO

Do you have any other disease, condition or problem not listed on this form? YES NO
Please describe

____
____

_______________________ ________
(Patient's Signature) (Date)

____
(Signature of Parent/Legal Guardian)