Patient Information Sheet

Date:_____

Patient Name: _____ Date of Birth_____

Address: _____

Phone:_____ Cell: _____ Email:_____

Social Security Number:_____ Driver's License Number: _____

Spouse Name:_____ Date of birth:_____ Phone:_____

Primary Insurance: Carrier Name:_____ Mailing Address: _____

_____ Provider#_____

ID Number: _____ Group Number: _____

Policy Holder Name:_____ SN:_____ Date of Birth:_____

Employment Information: Company Name: _____

Address: _____Phone:_____

Years Employed: _____ Occupation: _____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____ **Person Responsible for account:** _____ # _____

How did you hear about our Practice: Insurance Company: Yes / No Friend / Family Member: _____

Patients Responsibilities and Office Policies: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Towards these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time of services rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of preforming any treatment with our practice. We accept the following forms of payments Cash, Check, Visa, MasterCard, Discover.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer. Benefits and payments received are based on the terms of the contract negotiated between you and your employer based on plan. We are happy to help our patients understand their benefits in order to maximize their coverage. If we are in network with your dental plan, you are responsible for only your portion of the approved fee determined by your plan. We are required to collect the patient portion (deductible, Co -insurance or copay that is not covered by the insurance. If our estimate is less then the amount due on the account revised to reflect or adjusted amount.

Appointments: We reserve the doctors time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it impacts the quality of service we provide. To maintain utmost service and care, we do require a 24-hour notice to cancel or reschedule an appointment failure to notify the office will result in a charge $50.00. The fee for a missed appointment will need to be paid before your next appointment.

Authorization's: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental office to preform any necessary dental services that I may need and have consented during diagnosis and treatment. _____ (Initial)

I have read the information above and agree to the financial and scheduling terms. _____(Initial)

I authorize the release of information necessary to process my dental claims and to other doctors involved in my treatment plan. _____(Initial)

I hereby authorize payment directly to this doctor otherwise payable to me. Yes / No (Circle One) _____ (Initial)

OVER →

DO YOU HAVE OR HAVE YOU EVER HAD:

ARTIFICIAL BONE/JOINT	❑ NO	❑ YES	HIGH BLOOD PRESSURE	❑ NO	❑ YES
ABNORMAL HEART CONDITIONS WHAT?	❑ NO	❑ YES	HEPATITIS - A, B, C & NON A - NON B Date of Illness:	❑ NO	❑ YES
HEART ATTACK	❑ NO	❑ YES	GLAUCOMA	❑ NO	❑ YES
MITRAL VALVE PROLAPSE	❑ NO	❑ YES	ASTHMA	❑ NO	❑ YES
HEART MURMUR	❑ NO	❑ YES	DRUG ABUSE	❑ NO	❑ YES
RHEUMATIC FEVER	❑ NO	❑ YES	ALCOHOLISM	❑ NO	❑ YES
STROKE	❑ NO	❑ YES	SEIZURE DISORDER	❑ NO	❑ YES
DIABETES	❑ NO	❑ YES	BRAIN INJURY	❑ NO	❑ YES
CANCER/CHEMOTHERAPY WHEN?	❑ NO	❑ YES	MENTAL/PHYSICAL HANDICAPWHAT?	❑ NO	❑ YES
EMPHYSEMA	❑ NO	❑ YES	SMOKE OR CHEWING TOBACCO	❑ NO	❑ YES
SEXUALLY TRANSMITTED DISEASE	❑ NO	❑ YES	ANEMIA: "LOW BLOOD"	❑ NO	❑ YES
HIV/AIDS	❑ NO	❑ YES	KIDNEY/LIVER PROBLEM	❑ NO	❑ YES
EXPOSURE TO SOMEONE WITH AIDS	❑ NO	❑ YES	ABNORMAL BLEEDING/HEMOPHILIA	❑ NO	❑ YES
TUBERCULOSIS	❑ NO	❑ YES	SICKLE CELL TRAIT	❑ NO	❑ YES
THYROID PROBLEMS	❑ NO	❑ YES	ARTHRITIS	❑ NO	❑ YES
TMJ PROBLEMS	❑ NO	❑ YES	OTHER PHYSICAL CONDITIONS	❑ NO	❑ YES
ALLERGIC REACTION (HIVES SWELLING) TO: - PENICILLIN	❑ NO	❑ YES			
- CODEINE	❑ NO	❑ YES	- ERYTHROMYCIN	❑ NO	❑ YES
- ASPIRIN	❑ NO	❑ YES	- SULFA	❑ NO	❑ YES
- LATEX	❑ NO	❑ YES	- DENTAL ANESTHETIC - "NOVOCAIN"	❑ NO	❑ YES
HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS? IF YES, FOR WHAT? _____	❑ NO	❑ YES	ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?	❑ NO	❑ YES
ARE YOU TAKING ANY BLOOD THINNERS (COUMADIN, HEPARIN, ASPIRIN, ETC....)?	❑ NO	❑ YES	ARE YOU TAKING ANY MEDICATIONS? IF YES, PLEASE LIST MEDICATIONS	❑ NO	❑ YES
ARE YOU TAKING HERBAL SUPPLEMENTS?	❑ NO	❑ YES	ARE YOU TAKING ANY WEIGHT LOSS MEDICATIONS?	❑ NO	❑ YES
FOR WOMEN: ARE YOU TAKING BIRTH CONTROL PILLS?	❑ NO	❑ YES	FOR WOMEN: ARE YOU PREGNANT? WEEKS # ____	❑ NO	❑ YES
NAME OF YOUR DENTIST TELEPHONE			NAME OF YOUR PHYSICIAN TELEPHONE		