PATIENT INFORMATION

Patient's full name ______________________________ Today's Date __________

SS#________________ Birthdate ____________ Age _____ Sex _____ WT _____

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:

☐ Medicare #__________________ ☐ 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 any 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 a 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

Rheumatic Fever, Heart disease, Cardiovascular diseases, Heart Attack, High blood pressure

Stroke, Asthma, Seizures, Diabetes, Hepatitis, Latex Allergy

Stomach ulcers, Kidney trouble, Venereal disease, Anemia, Abnormal bleeding

Artifical 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 been tested positive for the AIDS virus? .... Y N
9. Do you take?: Coumadin Plavix Aspirin .... Y N
10. Are you taking any drugs or medicines? .... Y N
    a.) If so, what medications. ____________
11. Are you allergic to any medications? .... Y N
    Please list ____________
    ____
12. Have you had any serious trouble associated with any previous dental treatment? .... Y N
    a.) If so, explain ____________
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: ____________

REVIEWED BY: Dr. ____________

Form Updated ______ ______

(dates initials) ______ ______