PATIENT INFORMATION SHEET

Date: _____

Patients Name: _____ Sex: **M F** Marital Status: **M S W D**

Birthdate: _____ Age: _____ SSN: _____

Mailing Address: _____City/State/Zip: _____

Phone # home: _____ cell: _____ work: _____

Email: _____ No. of Dependents: _____

Employer: _____ Occupation: _____

Student? **F/T P/T** Name of school:_____

Spouse: _____ Birthdate:_____ SSN:_____

Emergency Contact Person: _____ Phone: _____

Address: _____Relationship:_____

Has a member of your family been treated in our office? **YES NO** Name:_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person: _____ Relationship:_____

Birthdate: _____ Age: _____ SSN: _____ Phone:_____

Mailing Address:_____ City/State/Zip:_____

Employer: _____ # of Years Employed: _____

Address: _____ Phone: _____

DENTAL INSURANCE INFORMATION

(Use your Identification Card)

Subscribers Name: _____ Birthdate: _____ SSN: _____

Relationship to Patient named above: **SELF SPOUSE CHILD OTHER:**_____

Insurance Company: _____ Phone: _____

Claims Address: _____

Subscriber ID#:_____ Group #:_____

Whom may we thank for your referral? _____

MEDICAL HISTORY

_____

PATIENT NAME: DATE OF BIRTH: PHYSICIAN'S NAME: _____PHONE:

_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

1. Do you consider yourself to be in good health? **YES** **NO**
2. Are you now or have you been under a physician's care within the past year? **YES** **NO**
   If Yes, specify condition being treated _____
   _____
3. Do you take any medications, including birth control pills? **YES** **NO**
   If Yes, please specify name and purpose of medications: _____
   _____
   _____
4. Do you have or have you ever had any heart or blood problems? **YES** **NO**
5. Have you ever been told that you have a heart murmur? **YES** **NO**
6. Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? **YES** **NO**
7. Do you have or have you ever had high blood pressure? **YES** **NO**
8. Do you bleed or bruise easily? **YES** **NO**
9. Have you ever been diagnosed as being HIV positive or having AIDS? **YES** **NO**
10. Have you ever had hepatitis or liver disease? **YES** **NO**
11. Have you ever had: ☐ rheumatic fever ☐ asthma ☐ any blood disorder ☐ diabetes **YES** **NO** ☐ rheumatism ☐ arthritis ☐ tuberculosis ☐ venereal disease ☐ heart attack ☐ kidney disease ☐ immune system disorders ☐ heart disease ☐ endocarditis ☐ other disease, specify:
    _____
12. Have you ever had an unusual reaction or are you allergic to any of the following drugs: **YES** **NO** ☐ Penicillin ☐ Aspirin ☐ Acetaminophen ☐ Ibuprofen ☐ Codeine ☐ Barbiturates ☐ Sulfa Drugs ☐ Other
13. Are you subject to fainting? **YES** **NO**
14. Have you ever had any severe reaction to dental treatment or local anesthetics? **YES** **NO**
15. Are you allergic to any local anesthetic? **YES** **NO**
16. Do you have any other allergies? ***If Yes,*** please describe: _____ **YES** **NO**
17. Have you ever had a nervous breakdown or undergone psychiatric treatment? **YES** **NO**
18. Have you ever received counseling for use of alcohol and/or prescription drugs? **YES** **NO**
19. Women: Are you pregnant? **YES** **NO**
20. Are you now in pain? **YES** **NO**
21. How long ago did you last see a dentist? _____
22. Who was your previous dentist? _____
23. Do you think that your teeth are affecting your general health in any way? **YES** **NO**
24. Do you have or have you ever had bleeding or sensitive gums? **YES** **NO**
    If Yes, have you seen your physician or cardiologist for a cardiac evaluation? **YES** **NO**
25. Have you ever used or are you now using tobacco or alcohol? **YES** **NO**
26. Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? **YES** **NO**

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)

(Rev. 11/13)

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 1.5% per month/18% per annum* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, Parent or Guardian: _____ Date _____

Relationship to Patient: _____

*The interest rate charged may be at the discretion of your office or accountant.

(Rev.4/10)