PATIENT INFORMATION SHEET

Date:_____ **Referred By:**_____

Patient's Name:_____ **SSN:**_____ **Birthdate:**_____ **Age:**

Address: _____ **C/S/Z:**_____

Phone #:_____ **Sex: M F Marital Status: M S W D No. of Dependents:**

Employer:_____ **Phone:**_____ **Occupation:**_____

Student? F/T P/T Name of School:_____

Spouse:_____ **SSN:**_____ **Occupation :**_____

Employer:_____ **Phone:**_____

Emergency Contact Person:_____ **Relationship:**_____

Address:_____ **Phone:**_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person:_____ **Relationship:**_____

Residence Address:_____ **C/S/Z:**_____

Hm. Phone #:_____ **SSN:**_____

Employer: _____ **# of Years Employed:**

Employer's Address:_____ **C/S/Z:**

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW;

PRIMARY INSURANCE

(Use your Identification Card)

Insured's Name:_____ **SSN:**_____

Patient's Relationship to Insured: Self:_____ **Spouse:**_____**Child:**_____**Other:**_____

Employer:_____ **Phone #:**_____ **Union Local:**_____

Insurance Company:_____ **Group # :**_____

Claims address:_____

SECONDARY INSURANCE

(Use your Identification Card)

Insured's Name:_____ **SSN:**_____

Patient's Relationship to Insured: Self:_____ **Spouse:**_____ **Child:**_____**Other:**_____

Employer:_____ **Phone #:**_____ **Union Local:**_____

Insurance Company:_____ **Group # :**_____

Claims address:_____

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
	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?		
11.	Have you ever had: rheumatic fever_____; asthma_____; any blood disorder_____; diabetes_____; rheumatism_____; arthritis_____; tuberculosis_____; venereal disease____; heart attack_____; kidney disease_____; immune system disorders_____; heart disease or endocarditis_____ other disease_____:Specify_____	YES	NO
12.	Have you ever had an unusual reaction or are you allergic to any of the following drugs: Penicillin_____; Aspirin_____; Acetaminophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other	YES	NO
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)

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. A $50.00 fee will be charged for any missed appointments without 24 hours prior notice.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child) 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 reviewed the office's Privacy Policies and a copy is available to me if I request a written copy. 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 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_____