



WELCOME

New Patient Data

Date: _____

Patient Name: Last _____ First _____ MI _____

What you prefer to be called: _____ Male _____ Female _____

Birth Date: ____/____/____ Age: _____ SS# _____

Mailing Address: _____

City

State

Zip

Home Phone #: _____ Cell #: _____

Work Phone #: _____ Ext _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

Occupation: _____

Status: Minor__ Single__ Married__ Divorced__ Separated__ Widowed__

Spouse's name: _____

Patient Name: _____

ACCOUNT INFORMATION:

Person Responsible For Account:

Name: _____

Relation to Patient: _____

Mailing Address: _____

SS#: _____

Drivers License #: _____

Work Phone #: _____

Cell Phone #: _____

Payment Method: Cash _____ Check _____

Credit Card #: _____

Spouse's Name: _____

Occupation and Employer: _____

Patient Name: _____

INSURANCE DATA:

Primary Dental Insurance (can scan card data into our system)

Company Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Insured's SS #: _____

Insured's Date of Birth: _____

Insured's Employer: _____

Group # (Plan, Local, or Policy #): _____

Relation to Patient: _____

_____ (initial) **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid for by my insurance company.**

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation? _____

Home Phone # or Cell#: _____

Work Phone #: _____

Who is your medical doctor? _____

M.D.'s Phone #: _____

Patient Name: _____

MEDICAL HISTORY: DATE _____

ALLERGIES (medication and other causes): _____

Medications that you currently take (including herbal supplements):

Date of Last Physical Exam: _____

Name of Primary Care Physician: _____

Do you have or ever had any of the following diseases or medical conditions? Mark space to the left with a + if you have a history of this condition.

_____ Heart Attack

_____ Stroke

_____ Prosthetic Heart Valve

_____ Congenital Heart Disease

_____ Heart Disease

_____ Previous Infectious Endocarditis

_____ Heart Transplant

_____ Heart Surgery /pacemaker history

_____ Coronary Artery Stents

_____ Total Joint Replacement (date of surgery; previous joint infection?)

_____ Bleeding problems (take medication that thins blood? Hemophilia?)

_____ Hypertension (High Blood Pressure?)

_____ Angina (Chest Pains)

_____ Arrhythmias (abnormal rhythms of heart?)

_____ Diabetes (Insulin dependent?)

_____ Congestive Heart Failure

Patient Name: _____

- _____ Tobacco Use
- _____ Alcohol Use
- _____ Immunosuppression (spleen removed, medication caused or disease related)
- _____ Systemic Lupus Erythematosus (SLE)
- _____ Rheumatoid Arthritis (RA)
- _____ Anxiety
- _____ AIDS/HIV
- _____ Cancer (Radiation and/or Chemotherapy?)
- _____ Asthma
- _____ Hepatitis
- _____ Liver problems
- _____ Kidney problems
- _____ Respiratory problems (Emphysema?)
- _____ Stomach problems (ulcer?)
- _____ Reflux (GERD?)
- _____ Colitis (Crohns Disease?)
- _____ Psychiatric problems
- _____ Neurological Disorder
- _____ Alcohol/Drug abuse
- _____ Venereal Disease
- _____ Tuberculosis (TB)
- _____ Sinus problems
- _____ TMJ/ Jaw injury and/or pain
- _____ Shingle history
- _____ Arthritis
- _____ Fainting/Seizures/Epilepsy
- _____ Headaches (severe/frequent?)
- _____ Neck pain
- _____ Back Problems
- _____ Glaucoma
- _____ Anemia
- _____ Pregnant
- _____ Please list any other Medical Condition that has not been listed that you may have had previously diagnosed:

Patient Name: _____

Dental History:

Date of Last Dental Exam? _____

Previous dentist? _____

History of dental X-Rays taken in past three years? _____

_____ Premedication with antibiotics for dental visits in past?

_____ Allergy to dental anesthetics? (Lidocaine?)

_____ History of any complication as the result of dental injections? (Paresthesia?)

_____ Allergy to any dental materials? (Latex? Nickel? Acrylic?)

_____ Periodontal disease history?

_____ Orthodontic History?

_____ Wisdom teeth removed?

_____ Wear a Dental Prosthesis?

_____ Facial trauma?

_____ TMJ /Jaw problems/clicking or popping?

_____ Clench or Grind teeth?

_____ Oral sores in past?

_____ Cold sores in past?

_____ Dental Anxiety?

_____ Dry Mouth?

_____ Bad breath concerns?

_____ Cosmetic dental improvements? (Whitening?, Veneers? Other?)

_____ Please describe you current home care techniques:

_____ Oral Cancer? (Screening?)

_____ Any particular mouth habits? (lip, cheek or tongue biting, foreign objects between teeth, etc? _____

_____ Other history that you would like to inform us of would be appreciated:

DENTIST SIGNATURE: _____

DATE: _____

Patient Name: _____

CONFIDENTIALITY OF YOUR HEALTH INFORMATION

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you a copy of “Notice of Privacy Practices” for this office. By signing below you are indicating that you have received a copy of the “Notice of Privacy Practices” for this practice and realize that you may call the office regarding such practices at any time.

Your dental records will be maintained in a digital format with any hard copies of your data locked up nightly. We use password protected access for all computer data and have a contract with a dental IT company to maintain a secure server.

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

The following person or persons have my permission to have access to my dental record and I will allow the Doctor to discuss my dental care with the following individuals:

Signature and Date: _____

We want to communicate with our patients in a manner that best fits their needs. Please indicate which method we should use to confirm appointments:

_____ Phone contact ?

_____ E-mail message?

_____ Text message on your mobile?

_____ Leave a message on home phone?

_____ Leave a message on work phone?

_____ Leave a message with spouse/secretary/other?

_____ Other method that is not listed?

Patient Name: _____

FINANCIAL POLICY

Our policy requires payment in full for all services rendered at the time of visit, unless arrangements have been made with the office. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims for these services.

The non sufficient funds fee is \$25 on all returned checks.

Patients are requested to provide 48 hour notice of any change in their appointment. Failure to notify the office of changes may result in a fee of \$50.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to this information I have provided.

SIGNATURE: _____ DATE: _____

UPDATED: 6/1/08 KK