Patient Information

Thank you for choosing our practice for your dental needs! Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We are happy to help!

Name: _____ Date: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: (Please Circle) Female Male **Birthdate**: _____ Email: _____

Cell Phone #: (_____) _____ Alternative Phone Number: (_____) _____

(Please Circle): Minor Single Married Separated Divorced Widowed Other

Patient Employer/ School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone Number: _____

Alternative Emergency Contact: _____Phone Number: _____

How did you hear about us? (Please Circle) Insurance Groupon Internet Phone Book Friend Other: _____

If referred by a friend, Name of Friend: _____

Responsible Party

(Fill out if patient is under the age of 18)

Person Responsible for this Account: _____ SS#: _____

Relationship to Patient: _____ Phone Number: (_____) _____

Address (If different from above): _____ City: _____ State: _____ Zip: _____

Dental Insurance Information (If Applicable)

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SS#: _____ Subscriber ID: _____

Name of Employer: _____ Employer Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group Number: _____

Additional Dental Insurance: _____

Dental History

Name: _____ Age: _____ Date of last exam: _____

Former Dentist: _____ Date of last dental x-rays: _____

Reason for Today's Visit: _____

How often do you brush your teeth? _____ How often do you floss? _____

Please Circle if Applicable:

Bad Breath	Grinding Teeth	Sensitivity to Heat
Bleeding Gums	Loose Teeth or Broken Fillings	Sensitivity to Sweets
Clicking or Popping of Jaw	Periodontal Treatment	Sensitivity when Biting
Food Collection between Teeth	Sensitivity to Cold	Sores or Growths

Medical History

Physician _____ Date of Last Visit: _____

Current Medications: _____ **ANY MEDICATION ALLERGIES**: _____

_____ _____

Please Circle if Applicable: **NO CURRENT MEDICATIONS** **NO ALLERGIES**

Women Only (Please Circle): **Are you Pregnant**? YES NO **Nursing**? YES NO Birth Control? YES NO

If YES, how many weeks? _____

Please Circle Any Conditions Below if Applicable: (If none, please circle none) **NONE**

AIDS/HIV	Congenital Heart Lesions	Hepatitis	Rheumatic Fever
Anemia	Cortisone Treatments	Hernia Repair	Scarlet Fever
Arthritis, Rheumatism	Cough, Persistent	High Blood Pressure	Shortness of Breath
Artificial Heart Valves	Cough up Blood	HIV Positive	Skin Rash
Artificial Joints	Diabetes	Jaw Pain	Stroke
Asthma	Epilepsy/Seizures	Kidney Disease	Swelling of Feet or Ankles
Back Problems	Fainting	Liver Disease	Thyroid Problems
Bleeding Abnormally	Glaucoma	Mitral Valve Prolapse	Tobacco Habit
Blood Disease	Headaches	Nervous Problems	Tonsillitis
Cancer	Heart Murmur	Pacemaker	Tuberculosis
Chemical Dependency	Heart Problems	Psychiatric Care	Ulcer
Chemotherapy	Describe: _____	Radiation Treatment	Venereal Disease
Circulatory Problems	Hemophilia	Respiratory Disease	Pins, Plates, Screws

Have you ever taken any of the medications listed below? (Please Circle)

Diet Medications:	Dexfenfluramine	Fen-Phen	Pondimin	Redux
Blood Thinners:	Coumadin	Warfarin		
Other:	Levoxyl	Synthroid		

Office Policy Consent Form

- ## Family Members in the Treatment Areas

We have limited amount of space in the treatment areas of our office. Our facilities do not allow for non-patients to be present chair side. One adult may accompany a minor to the treatment areas if you desire. However, we do ask that no more than one family member be present. Also, please arrange for childcare when appropriate. We cannot be responsible for managing children that are with adults undergoing treatment. Our services require full attention of our staff and doctors.

- ## Limitations of Insurance Coverage

Insurance may not cover every procedure that we recommend. Some might include: Nitrous Oxide, Temporary Dentures or Partials, Removal and Recementation of Crowns or Bridges, Bleaching or Cosmetic Work. I understand that what might be quoted as my portion (co-payment) is only an **ESTIMATE**.

- ## Filing of Dental Insurances for the Patient

We routinely file insurance claims for the patient as a courtesy. The patient is still fully responsible for payment of all charges incurred within the office. We reserve the right to discontinue filling insurance claims for the patient at any time. If this occurs, the patient will then be responsible for payment of all fees in full at the time service is rendered.

Agreement of Patient Information and Office Consent

To the best of my knowledge, the information I filled out is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have dental insurance coverage and assign directly to Vintage Dental Spa, PLLC, all insurance benefits, if any. I understand that I am financially responsible for all charges whether or not paid by insurance. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining estimated insurance benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative | Date

HIPPA Agreement

Name of Practice: Vintage Dental Spa

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledge of receipt of same. You may refuse this acknowledgement form.

By signing this form, I confirm that I have received, or was able to review, a copy of the Notice of Privacy Practices.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please Print Name of Patient, Parent, Guardian or Personal Representative	Date