# PATIENT INFORMATION FORM

NAME _____ (FIRST / MI / LAST) AGE _____ SEX _____ HOME PHONE (  )

ADDRESS _____ APT. NO. _____ WORK PHONE (  )

CITY _____ STATE _____ ZIP _____ OTHER PHONE (  )

BIRTHDATE _____ (MONTH / DAY / YEAR) SSN _____ _____ (DRIVER'S LICENSE NUMBER / STATE)

EMPLOYER/OCCUPATION _____ ADDRESS _____

IN CASE OF EMERGENCY, CONTACT: _____ RELATIONSHIP _____ PHONE (  )

ARE ANY OF YOUR FAMILY MEMBERS PATIENTS OF THE PRACTICE? ☐YES ☐NO NAME _____ RELATIONSHIP _____

IF THE PERSON RESPONSIBLE FOR THE ACCOUNT IS DIFFERENT THAN THE PATIENT, PLEASE FILL IN THIS SECTION:

NAME _____ (FIRST / MI / LAST) RELATIONSHIP _____ HOME PHONE (  )

ADDRESS _____ APT. NO. _____ WORK PHONE (  )

CITY _____ STATE _____ ZIP _____ EMPLOYER _____

BIRTHDATE _____ (MONTH / DAY / YEAR) SSN _____ ADDRESS _____

PRIMARY DENTAL INSURANCE (LEAVE BLANK ONLY IF NO DENTAL BENEFITS)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ GROUP NO. _____

POLICY NUMBER _____

NAME OF INSURED IF DIFFERENT THAN PATIENT.

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SS NUMBER _____

EMPLOYER _____

MEDICAL INSURANCE

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ GROUP NO. _____

POLICY NUMBER _____

NAME OF INSURED IF DIFFERENT THAN PATIENT.

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SS NUMBER _____

EMPLOYER _____

## FINANCIAL AGREEMENT

**I. General**

1. The financial policy of our practice is that payment is due at the time of service, unless financial arrangements have been made with the office manager prior to any treatment.
2. Cash, personal checks, money orders, Mastercard, Visa and Discover are accepted for payment.

**II. Insurance**

1. Dental insurance coverage is a contract between the patient and the insurance company. We will coordinate claims and payments with primary insurance only.
2. All necessary information must be provided to us so that we can submit claims for you. Without this information we will require that payment be made at the time of service.
3. We ask that you carefully read and understand your policy so that you are aware of restrictions, deductible and co-pays.
4. Your estimated co-pay and deductible must be paid at the time the service is rendered.

**III. Broken Appointments**

1. Cancellations with less than a 24 hour notice or broken appointments will result in a fee for the time that was allotted and/or denial to reappoint.

**IV. Delinquent Accounts**

1. To avoid an additional FINANCE CHARGE on the balance of your bill for service, pay the total amount due in full with SIXTY (60) days of the bill date. The rate of INTEREST assessed is a monthly rate of ONE and ONE HALF percent (1.5%) for a corresponding annual PERCENTAGE RATE of EIGHTEEN percent (18%).
2. As to any unpaid account turned over to the practice's attorney for collection, the patient agrees to be responsible for all costs of collection including attorney fees equal to 25% of the outstanding balance. Said costs are due whether or not suit is filed.

**V. Financial Guarantee**

1. I, the undersigned guarantor, agree to be financially responsible for any unpaid portion of the above named patient's bill.

_____ Signature of Guarantor

_____ Date

## MEDICAL HISTORY

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental or medicalcare. This information is strictly confidential. Thank you for completing all questions in detail.

**DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:**

| | YES | NO |
|---|---|---|
| ANY HEART PROBLEMS | ☐ | ☐ |
| HEART MURMUR* | ☐ | ☐ |
| MITRAL VALVE PROLAPSE* | ☐ | ☐ |
| HEART VALVE DEFECT* | ☐ | ☐ |
| HEART VALVE REPLACEMENT* | ☐ | ☐ |
| RHEUMATIC FEVER* | ☐ | ☐ |
| ARTIFICIAL JOINT (HIP/KNEE)* | ☐ | ☐ |
| ANGINA | ☐ | ☐ |
| STROKE | ☐ | ☐ |
| HEART ATTACK | ☐ | ☐ |
| BYPASS | ☐ | ☐ |
| PACEMAKER | ☐ | ☐ |
| HIGH BLOOD PRESSURE | ☐ | ☐ |
| LOW BLOOD PRESSURE | ☐ | ☐ |
| ANY BLEEDING DISORDERS | ☐ | ☐ |
| ANEMIA | ☐ | ☐ |
| HEMOPHILIA | ☐ | ☐ |
| SICKLE CELL TRAIT | ☐ | ☐ |
| BLOOD TRANSFUSIONS | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| DO YOU SMOKE | ☐ | ☐ |
| LUNG/BREATHING PROBLEMS | ☐ | ☐ |
| ASTHMA | ☐ | ☐ |
| BRONCHITIS | ☐ | ☐ |
| EMPHYSEMA | ☐ | ☐ |
| TUBERCULOSIS | ☐ | ☐ |
| SINUS TROUBLE | ☐ | ☐ |
| DIFFICULTY IN HEALING | ☐ | ☐ |
| DIABETES | ☐ | ☐ |
| THYROID PROBLEMS | ☐ | ☐ |
| ADRENAL/PITUITARY PROBLEMS | ☐ | ☐ |
| LIVER PROBLEMS / DYSFUNCTION | ☐ | ☐ |
| HEPATITIS / JAUNDICE | ☐ | ☐ |
| KIDNEY PROBLEMS / DYSFUNCTION | ☐ | ☐ |
| STOMACH TROUBLE / ULCERS | ☐ | ☐ |
| NERVOUS OR MENTAL DISORDER | ☐ | ☐ |
| EPILEPSY OR SEIZURES | ☐ | ☐ |
| ALCOHOLISM | ☐ | ☐ |
| DRUG ABUSE | ☐ | ☐ |

| ALLERGIC/REACTION (HIVES/ SWELLING) TO: | YES | NO |
|---|---|---|
| PENICILLIN | ☐ | ☐ |
| ERYTHROMYCIN | ☐ | ☐ |
| SULFA | ☐ | ☐ |
| CODEINE | ☐ | ☐ |
| ASPIRIN | ☐ | ☐ |
| LATEX | ☐ | ☐ |
| LOCAL ANESTHETIC (XYLORAINE, NOVOCAIN) | ☐ | ☐ |
| EPINEPHRINE OR ADRENALINE | ☐ | ☐ |
| OTHER MEDICATIONS OR SUBSTANCES? PLEASE LIST: | ☐ | ☐ |
| CANCER / TUMOR | ☐ | ☐ |
| OTHER GROWTHS | ☐ | ☐ |
| CHEMOTHERAPY / RADIATION THERAPY | ☐ | ☐ |
| SEXUALLY TRANSMITTED DISEASES | ☐ | ☐ |
| OTHER INFECTIOUS DISEASES | ☐ | ☐ |
| HIV / AIDS | ☐ | ☐ |
| ARE YOU PREGNANT? | ☐ | ☐ |

*DO YOU NEED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL APPOINTMENTS? ☐ YES ☐ NO ☐ DON'T KNOW NAME OF ANTIBIOTIC: _____

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS NOT NOTED ABOVE? ☐ YES ☐ NO WHAT? _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? ☐ YES ☐ NO WHY? _____

PHYSICIAN'S NAME, ADDRESS AND PHONE: _____

**ARE YOU PRESENTLY TAKING ANY MEDICATIONS, PILLS, OR TONICS?** ☐ YES ☐ NO **LIST:** _____ FOR: _____

(I.E., BLOOD PRESSURE, BIRTH CONTROL, STEROIDS, HORMONES) _____ FOR: _____

(BLOOD THINNERS INCLUDING ASPIRIN) _____ FOR: _____

**IS THERE ANY CONDITION OR PROBLEM RELATING TO YOUR MEDICAL HISTORY THAT HAS NOT BEEN MENTIONED?** ☐ YES ☐ NO EXPLAIN: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL INFORM THE DENTIST OF ANY CHANGES IN MY HEALTH STATUS OR MY MEDICATIONS.

DATE _____ PATIENT / GUARDIAN SIGNATURE _____ DOCTOR / HYGIENIST SIGNATURE _____

INITIAL REVIEW OF PATIENT MEDICAL HISTORY

MEDICAL ALERT RECOMMENDED: ☐ YES ☐ NO

PREMEDICATION RECOMMENDED: ☐ YES ☐ NO

RX: _____

INTERVIEWER NOTES _____

REVIEW OF PATIENT MEDICAL HISTORY:

| NO CHANGE | CHANGE | LIST: | DATE | PATIENT/GUARDIAN SIGNATURE | DOCTOR / HYGIENIST SIGNATURE |
|---|---|---|---|---|---|
| ☐ | ☐ | | | | |
| ☐ | ☐ | | | | |
| ☐ | ☐ | | | | |
| ☐ | ☐ | | | | |
| ☐ | ☐ | | | | |
| ☐ | ☐ | | | | |
| ☐ | ☐ | | | | |