



Welcome to our Practice

**PATIENT INFORMATION:**

Date: _____

 Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____Sex: Male Female Birth Date _____ Age _____ Soc.Sec.# _____

Street _____ Apt _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Have you ever been a patient of our practice? Yes No Has a family member ever been a patient of our practice? Yes NoReferred By _____ Dentist _____
FIRST NAME LAST NAME FIRST NAME LAST NAMEOrthodontist _____ Medical Dr. _____
FIRST NAME LAST NAME FIRST NAME LAST NAMEDriver's License # _____ Nearest relative not living with you _____
NAME AND PHONE NUMBER

Employer _____ Business Phone (____) _____

Personal Payment Type: Cash Check Credit Card We accept: Visa, Mastercard, Discover and CareCredit

In case of emergency _____ Phone _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT: Self (If self, skip this section) Spouse Father Mother Other _____

Name _____

Sex: Male Female Birth Date _____ Age _____ Soc.Sec.# _____

Street _____ Apt _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell (____) _____

Driver's License # _____ Employer _____ Bus. Phone (____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE) Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____Sex: Male Female Birth Date _____ Age _____ Soc.Sec.# _____

Street _____ Apt _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Employer _____ Business Phone (____) _____

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:			WOMEN ONLY: (QUESTIONS 64-67)		
YES	NO	NOTES	YES	NO	NOTES
54. Immune system problems?	<input type="checkbox"/>	<input type="checkbox"/>	64. Is there a possibility of pregnancy?.....	<input type="checkbox"/>	<input type="checkbox"/>
55. Are you on a diet?	<input type="checkbox"/>	<input type="checkbox"/>	65. Expected delivery date? _____		
56. Cancer/radiation/chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	66. Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
57. History of alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>	67. Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
58. History of drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/OB/gyn for assistance regarding other methods of birth control.		
59. Contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	IS THERE A FAMILY HISTORY OF:		
60. Eye disease/glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>	68. Cancer?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
61. Mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>	69. Diabetes?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			70. Heart disease?....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			71. Anesthesia issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ARE YOU ALLERGIC TO, OR HAD A REACTION TO:			ARE YOU NOW TAKING:		
YES	NO	NOTES	YES	NO	NOTES
72. Local anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	87. Any kind of medication, drug, pills?	<input type="checkbox"/>	<input type="checkbox"/>
73. Penicillin?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin, Vitamin E, Ginko biloba, Aggrenox,	<input type="checkbox"/>	<input type="checkbox"/>
74. Other antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	89. Have you ever taken diet pills?	<input type="checkbox"/>	<input type="checkbox"/>
75. Sulfa drugs?	<input type="checkbox"/>	<input type="checkbox"/>	or homeopathic remedy?	<input type="checkbox"/>	<input type="checkbox"/>
76. Sodium pentothal/valium/ other tranquilizers?	<input type="checkbox"/>	<input type="checkbox"/>	91. Are you taking, or have you ever taken, bone density meds, or bisphosphonates	<input type="checkbox"/>	<input type="checkbox"/>
77. Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	92. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:		
78. Amoxicillin?	<input type="checkbox"/>	<input type="checkbox"/>			
79. Codeine or other narcotics?	<input type="checkbox"/>	<input type="checkbox"/>			
80. Other medications?	<input type="checkbox"/>	<input type="checkbox"/>	93. Please list any medications you are currently taking:		
81. Latex?	<input type="checkbox"/>	<input type="checkbox"/>	MEDICATION	DOSAGE	FREQUENCY
82. Soy?	<input type="checkbox"/>	<input type="checkbox"/>			
83. Eggs/ yolk	<input type="checkbox"/>	<input type="checkbox"/>			
84. Sulfites?	<input type="checkbox"/>	<input type="checkbox"/>			
85. Any known allergies?	<input type="checkbox"/>	<input type="checkbox"/>			
86. Please list any allergies other than drug allergies:					
If you are having surgery today , have you had anything to eat or drink in the last 6 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No Who is driving you home? _____			Is this visit related to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of accident? <input type="checkbox"/> Automobile <input type="checkbox"/> Work related <input type="checkbox"/> Other Date of injury _____ Insurance company handling the claim _____ Claim number _____ Name of attorney / adjustor _____ Telephone number (_____) _____		
Is there any condition concerning your health that the Doctor should be told about? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____					
Do you wish to speak to the doctor privately about anything? <input type="checkbox"/> Yes <input type="checkbox"/> No					
I certify that I have read and I understand the questions on this patient history form. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.					
X _____ Signature of patient (Parent or Guardian if Minor)		X _____ Reviewed by		X _____ Date	

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney fees and court costs.

X _____
Signature of patient (Parent or Guardian if Minor)

X _____
Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____
Signature of patient (Parent or Guardian if Minor)

X _____
Date

AUTHORIZATION

I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone concerning my appointment.

X _____
Signature of patient (Parent or Guardian if Minor)

X _____
Witness

X _____
Doctor

X _____
Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____
Signature of patient (Parent or Guardian if Minor)

X _____
Date

