PATIENT INFORMATION

Name: _____ ___ _____
Last Name MI First Name

Date of Birth: _____/_____/_____
Month Day Year

Title: Miss Ms. Mrs. Mr. Dr.
Marital Status: Single Married Divorced Separated Widowed

Social Security #: _____-_____-_____

Address (line 1): _____
Address (line 2): _____
City, State, Zip: _____

Home Phone: (____)_____
Work Phone: (____)_____
Cell Phone: (____)_____

Email: _____
Pharmacy Phone # & Address: _____
_____

Approximate Date of Last Checkup: _____
Were X-Rays Taken? Yes No

If Yes, Name of Dentist:_____

Who should we thank for your referral?

_____

In Case of Emergency, Please Notify:
Name: _____
Relationship: _____
Contact #: _____

MEDICAL HISTORY

Are you having any pain or discomfort at this time? Yes/No

Have you been hospitalized during the past 5 years? Yes/No
If yes please explain:

Are you currently under the care of a physician? Yes/No
If yes please explain:

Are you taking any medications at this time? Yes/No
If yes please list:

Are you ALLERGIC to any of the following?

__Aspirin __Darvon __Local Anesthetic __Tetracycline
__Amoxicillin/Penicillin __Erythromycin __Nitrous Oxide __Other_____
__Codeine __Latex __Sulfa Drugs

Do you/have you ever had any of the following conditions?

__Allergies/hay fever
__Anemia
__Arthritis/Rheumatism
__Artificial Joints/Joint Replacement
__ Asthma/Emphysema
__ Blood Transfusion
__ Bruise Easily
__ Cancer (If yes, what type and when?)
__ Chemotherapy/Radiation
__Diabetes
__Drug/Alcohol Addiction
__Epilepsy/Seizures
__Excessive Bleeding
__Fainting Spells/Dizzy Spells
__Glaucoma
__Heart Attack/Heart Failure
__Heart Murmur
__Hemophilia
__Hepatitis A/B/C
__High Blood Pressure
__HIV/AIDS
__Hives
__Jaw Pain
__Kidney Trouble
__Liver Disease
__Mitral Valve Prolapse
__Pacemaker
__Psychiatric Care
__Rheumatic Fever
__Sickle Cell Anemia
__Sinus Trouble
__Stomach Ulcers
__Stroke
__Thyroid Disease
__TMJ
__Tuberculosis
__Valve Replacement
__Venereal Disease
__OTHER: _____

WOMEN: Are you pregnant/nursing? Yes/No
Currently taking birth control pills? Yes/No

Are there any other medical concerns that we should be aware of? _____

Physicians Name: _____ Telephone Number:_____

The above information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

INSURANCE INFORMATION

Patient:

Name: _____, _____ Date of Birth: ___/___/___
Last Name First Name

Social Security #: _____-_____-_____

Relationship to Policy Holder (circle one): self spouse child other

Are you the responsible party for the account? __Yes __No

If no who is the responsible party? _____

Primary Insurance Subscriber/Policy Holder:

Name: _____, _____ Date of Birth: ___/___/___
Last Name First Name

Social Security #: _____-_____-_____

Address: _____City/State/Zip:_____

Benefit Information:

Employer Name: _____

Insurance Carrier: _____

Subscriber ID # (if applicable): _____

***Secondary Insurance Subscriber/Policy Holder (If applicable):**

Name: _____, _____ Date of Birth: ___/___/___
Last Name First Name

Social Security #: _____-_____-_____

Address:_____ City/State/Zip: _____

Benefit Information:

Employer Name: _____

Insurance Carrier: _____

Subscriber ID # (if applicable): _____

PATIENT HIPAA ACKNOWLEDGEMENT

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Consent for Services and Financial Policy

Insurance is **NOT** a guarantee of payment. Patient deductible and/or percentage are due at the time of your visit.

We accept the following payment options:

- **Payment by cash**
- **Payment by check**
- **Payment by credit card (Visa, MasterCard, Amex, & Discover)**
- **Flexible Spending**
- **Care Credit**

In the case of major work we will allow reasonable payment arrangements, which will enable you to use your credit card to automatically cover amounts not paid by your insurance. The amount we agree upon will be automatically billed to your credit card on a monthly basis.

BROKEN APPOINTMENT POLICY

Please realize that with all appointments, we have reserved time in the schedule especially for you. We respectfully request a minimum of 24 hours notice for all appointment cancellations. A fee will be assessed for missed appointments if no notice is given.

The office fee for broken appointments (without 24 hours advance notice) is $75.00.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date