Guardian Dental Care - Patient Information Form

Contact Information

Patient Name: _____ Gender: _____

Birth Date: D_____M_____Y_____ Hospitalization # _____

Family Status: Married ◯ Single ◯ Child ◯ Other ◯

Address:_____
Street Address City/Prov Postal Code

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

Email Address:_____

What is your preferred method of communication?

◯ Telephone ◯ Email ◯ Mail ◯ Text Message

Name of Employer: _____

Name and phone number (if known) of your family doctor:_____

How did you hear about us? ◯Yellow Pages ◯Website ◯ Person Other: _____

If referred to this office, name of the person who referred you: _____

Insurance Information

Insurance Company Name: _____

Policy/Plan #: _____ ID/Cert. #: _____

Insurance Plan Member: _____ Insured Member's Birth Date: D____ M____Y _____

Patient's Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Medical and Dental Information

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯No

Within the past year, have there been any changes in your general health? ◯ Yes ◯No

What is the date (or approximate date) of your last medical exam? _____

Please check any of the following to indicate "Yes" in response to the question:

◯ Have you ever had complications following dental treatment?

◯ Are you currently under the care of a physician due to a specific condition?

◯ Have you been hospitalized within the last 5 years due to a surgery or illness?

◯ Do you use tobacco (smoking, chewing, vaping)? _____

OVER --→

If you checked any of these answers, please explain:

_____

Please indicate if you have experienced any of the following:

◯ Allergies _____

◯ Artificial Joint_____ ◯ Blood Disorder ◯ Cancer_____ ◯ Diabetes (Type I)

◯ Diabetes (Type II) ◯ Epilepsy ◯ Hepatitis (A,B, or C) ◯ High Blood Pressure ◯ Heart Disease ◯ HIV+ (AIDS)

◯ Kidney Disease ◯ Mental Disorder ◯ Recreational Drugs ◯Stroke ◯ Suppressed Immune System

◯Tuberculosis ◯ Wheelchair

Do you have any other health issues or allergies not listed above that we should be aware of?

_____

Please list any prescription or non-prescription medications you are currently taking:

_____

What is the reason for your dental visit today? _____

When was your last visit to the dentist (if to a different office)? _____

Are you pregnant? ◯ Yes ◯ No If yes, when is the due date? _____

How often do you brush your teeth? ◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth? ◯ 1(+) a day ◯ 2-6 weekly ◯ 1-6 monthly ◯ Seldom ◯ Never

Do you have any dental implants? ◯ Yes ◯No

Are you happy with your mouth, teeth or smile? If not, what would you change?

_____

_____

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent or guardian:

Signature: _____ Date: _____

Relationship to Patient: _____