## **Patient Information Form**

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Within the past year, have there been any changes in your general health?       \[Yes]         Birth Date: D       Mail is the date (or approx. Date) of your last medical exam?         Family Status:       Married		Would you consider yourself to be in fairly good health? O Yes ONo				
What is the date (0 applox. Date) () your last interact data it reading the applox. Date) () your last interact data it reading the applox. Date) () your last interact data it reading the applications following to indicate "Yes" in response to the question:         Address:	Patient Name: Gender: M () F ()	Within the past year, hav	e there been any changes	in your general health?	⊖Yes ⊖No	
Address:       City/Piov       Potat Code         Street Address       City/Piov       Potat Code         Home Phone:	Birth Date: DMY	What is the date (or approx. Date) of your last medical exam?				
Street Address       City/Prov       Postal Code       Are you currently under the care of a physician due to a specific condition?         Home Phone: [ ]	Family Status: Married Single Child Other	Please check any of the following to indicate "Yes" in response to the question:				
Are you currently under the care of a physician due to a specific condition?         Are you currently under the care of a physician due to a specific condition?         Cell Phone:	Address:	◯ Have you ever had cor	O Have you ever had complications following dental treatment?			
Cell Phone:	Street Address City/Prov Postal Code	◯ Are you currently und	$\bigcirc$ Are you currently under the care of a physician due to a specific condition?			
Link Holders		⊖ Have you been hospita	$\bigcirc$ Have you been hospitalized within the last 5 years due to a surgery or illness?			
Winker by Gut preferent inertion of communications     Ortelephone     Name of Employer:     Name of Employer:     Name of Employer:     Please indicate if you have experienced any of the following:     Name and phone number (if known) of you family doctor:     Other:     Other:     If referred to this office, name of the person who referred you:     Insurance Information     Insurance Plan Name:   Policy/Plan #:   Policy/Plan #:   What is the reason for your dental visit to the dentist (if to a different office)?   What is the reason for your genant? Or yes ON If yes, when is the due date?	Email Address:	🔿 Do you use tobacco (s	O Do you use tobacco (smoking or chewing)?			
Name of Employer:       Please indicate if you have experienced any of the following:         Name and phone number (if known) of you family doctor:       Other:         How did you hear about us?       Yellow Pages       Website       Person         Other:       Hepatitis (A,B, or C)       HIV+ (AIDS)       Kidney Disease         Other:       Mental Disorder       Recreational Drugs       Stroke         Other:       Other:       Do you have any other health issues or allergies not listed above that we should be aw         Insurance Information       Please list any prescription or non-prescription medications you are currently taking:         Insurance Plan Name:       Policy/Plan #:       What is the reason for your dental visit today?         Insurance Plan Member:       Insured Member's Birth       WOMEN ONLY: Are you pregnant?       Yes       No       If yes, when is the due date?	What is your preferred method of communication?	If you checked any of the	If you checked any of these answers, please explain:			
Name and phone number (if known) of you family doctor:	○ Telephone ○ Email ○ Mail ○ Text Message (Phone Service Provider)					
How did you hear about us? Yellow Pages Website Person   Other:	Name of Employer:	Please indicate if you have experienced any of the following:				
How did you hear about us?       Yellow Pages       Website       Person         Other:	Name and phone number (if known) of you family doctor:		0	0	Cancer	
Other:	How did you hear about us? ()Yellow Pages ()Website () Person		÷ -	-	O Tuberculosis	
If referred to this office, name of the person who referred you:     Insurance Information     Insurance Plan Name:   Policy/Plan #:   Policy/Plan #: Insurance Plan Member: Insurance Plan	Other:	O Mental Disorder	O Recreational Drugs	Stroke		
Insurance Information       Do you have any other health issues or anergies not listed above that we should be aw         Insurance Information       Please list any prescription or non-prescription medications you are currently taking:         Insurance Plan Name:       Policy/Plan #:         ID/Cert. #:       What is the reason for your dental visit today?         Insurance Plan Member:       Insured Member's Birth         Date: DY       Insured Member's Birth		Suppressed Immune S	System			
Insurance Plan Name:       Policy/Plan #:         ID/Cert. #:       What is the reason for your dental visit today?         Insurance Plan Member:       Insured Member's Birth         Date: DMY       Mode If yes, when is the due date?		Do you have any other he	ealth issues or allergies not	t listed above that we sh	ould be aware of?	
ID/Cert. #:       Policy/Plant #         ID/Cert. #:       When was your last visit to the dentist (if to a different office)?         Insurance Plan Member:       Insured Member's Birth         Date: DMY       WOMEN ONLY: Are you pregnant? () Yes       No       If yes, when is the due date?	Insurance Information	Please list any prescriptio	Please list any prescription or non-prescription medications you are currently taking:			
Insurance Plan Member: Insured Member's Birth WOMEN ONLY: Are you pregnant? $\bigcirc$ Yes $\bigcirc$ No If yes, when is the due date? Date: D MY	Insurance Plan Name: Policy/Plan #:	What is the reason for yo	What is the reason for your dental visit today?			
Date: DMY	ID/Cert. #:	When was your last visit	When was your last visit to the dentist (if to a different office)?			
		WOMEN ONLY: Are you pregnant? O Yes O No If yes, when is the due date?				
Patient's Relationship to Insured: Self Spouse Child Other <u>Medical and Dental Information (Continued</u> )	Patient's Relationship to Insured: O Self O Spouse O Child O Other	Medical and Dental Infor	mation (Continued)			

## 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.

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?  $\bigcirc$  1(+) a day  $\bigcirc$  2-6 weekly  $\bigcirc$  1-6 monthly  $\bigcirc$  Seldom  $\bigcirc$  Never

Do you have any dental implants? O Yes ONo

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: \_\_\_\_\_\_