

CENTRE FAMILY DENTISTRY

PATIENT INFORMATION

TODAY'S DATE: _____ MINOR _____ SINGLE _____ MARRIED _____ EMAIL ADDRESS _____
DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER _____ - _____ - _____
NAME: _____ Male _____ Female _____
Last First M.
ADDRESS: _____
Street City State Zip
PHONE: () _____ () _____ () _____
Home Office Cell
OCCUPATION (OR SCHOOL) _____ GRADE _____
Has any member of your immediate family ever been seen in our office? _____ yes _____ no Name _____
How did you hear about our office? Person _____ Yellow Pages Internet ValPak Other _____

PARENT/GUARDIAN INFORMATION (If minor)

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER _____ - _____ - _____
RELATIONSHIP TO PATIENT: _____
NAME: _____ Male _____ Female _____
Last First M.
ADDRESS: _____
Street City State Zip
PHONE: () _____ () _____ () _____
Home Office Cell

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER _____ - _____ - _____
RELATIONSHIP TO PATIENT: _____
NAME: _____ Male _____ Female _____
Last First M.
ADDRESS: _____
Street City State Zip
PHONE: () _____ () _____ () _____
Home Office Cell

EMERGENCY CONTACT INFORMATION (Other than parent or guardian)

NAME: _____ RELATIONSHIP TO PATIENT: _____
Last First
ADDRESS: _____
Street City State Zip
PHONE: HOME () _____ WORK () _____ CELL () _____

DENTAL INSURANCE INFORMATION (Insurance Subscribers Information)

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER _____ - _____ - _____
NAME OF THE INSURED: _____
Last First M.
ADDRESS: _____
Street City State Zip
PHONE: () _____ () _____ () _____
Home Office Cell
EMPLOYER: _____
DENTAL INSURANCE CARRIER: _____
I.D. NUMBER: _____
GROUP NUMBER: _____
DENTAL INSURANCE PHONE #: _____
CLAIMS MAILING ADDRESS: _____
Street or P.O. Box City State Zip

PAYMENT PLAN AND POLICIES

PATIENT NAME _____

In effort to keep dental cost down while maintaining a high level of professional care, we have established the following payment options for the use of our patients. Fees may be paid as follows: PLEASE CHECK THE OPTION YOU WISH TO UTILIZE:

_____ CASH/CHECK/VISA/MASTERCARD at each visit

_____ DENTAL INSURANCE -I have dental insurance and agree to pay any portion not covered by my insurance. I understand I will be asked to pay the estimated portion not covered by my insurance at the time of service. If my insurance has not paid within 60 days I am responsible for the full balance.

_____ FINANCING THROUGH CARE CREDIT (Ask for details at front desk.)

I understand that if I fail to make my appointment, cancel or reschedule without giving the required 48 hours notice, I will be charged a minimum of \$75.00 or 1/2 of the total fee of the scheduled appointment.

I understand that all accounts outstanding more than 60 days from treatment date will bear interest at 1.5% per month. If collection efforts are required, I agree to pay all cost of collection including attorney fees. I understand that where appropriate, credit bureau reports may be obtained.

I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of the dental disease, deformity or treatment of dental emergency. These procedures may include radiographs, models, and intraoral examination. In the case of dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance.

X _____
Signature of responsible party **Date**

DENTAL HISTORY

Primary reason for this dental appointment?

Do you have a specific dental problem? If so, describe: _____ Yes No

Have you ever had a bad experience in a dental office? Explain _____ Yes No

Do you feel nervous about having dental treatment? Explain _____ Yes No

Do you have dental examinations on a routine basis? Last visit? _____ Yes No

Would you describe your present dental health as good? Comments _____ Yes No

Do you think you have active decay or gum disease? Comments _____ Yes No

Do your gums ever bleed? Discuss _____ Yes No

Do you floss on a routine basis? If so, how often? _____ Yes No

Do you like your smile? Why or why not? _____ Yes No

Have you ever been told you need to pre-medicate for a dental appointment? Why? _____ Yes No

MEDICAL HISTORY

Medical Doctor's Name: _____ Phone: _____

Are you under a doctor's care now? Why? _____ Yes No

Have you been hospitalized during the past two years? Why? _____ Yes No

Do you have a bleeding problems? _____ Yes No

Are you pregnant? _____ Yes No

Do you drink alcohol? Approximately how many drinks per week? _____ Yes No

Do you smoke? How many per day? _____ Yes No

Do you use street drugs? If any, please list _____ Yes No

MEDICAL HISTORY

PATIENT NAME _____

PLEASE CIRCLE YES OR NO FOR EACH OF THE FOLLOWING:

Heart (surgery, disease or attack)	Yes	No	Fainting or Dizzies	Yes	No	Glaucoma	Yes	No
High Blood Pressure	Yes	No	Chemotherapy	Yes	No	Abnormal Heart Cond.	Yes	No
Parathyroid Disease	Yes	No	Excessive Thirst	Yes	No	Mitral Valve Prolapse	Yes	No
Low Blood Pressure	Yes	No	Cold Sores	Yes	No	Cancer	Yes	No
Psychiatric Care	Yes	No	Venereal Disease	Yes	No	Thyroid Disease	Yes	No
Blood Transfusion	Yes	No	Epilepsy/Seizures	Yes	No	Sinus Trouble	Yes	No
Rheumatic Fever	Yes	No	Heart Pacemaker	Yes	No	Frequent Cough	Yes	No
Cortisone Medicine	Yes	No	Kidney Disease	Yes	No	Pain in Jaw Joint	Yes	No
Congenital Heart Lesion	Yes	No	Drug Addiction	Yes	No	Nervousness	Yes	No
Artificial Heart Valve	Yes	No	Liver Disease	Yes	No	Blood Disease	Yes	No
Hepatitis B (serum)	Yes	No	Scarlet Fever	Yes	No	Allergies	Yes	No
Bruise Easily	Yes	No	Asthma	Yes	No	Arthritis/Gout	Yes	No
X-ray/Colbat Tmt	Yes	No	Sore/Enlarged Lymph	Yes	No	Hemophilia	Yes	No
Chest Pain	Yes	No	Hay Fever	Yes	No	Yellow Jaundice	Yes	No
Shortness of Breath	Yes	No	Diabetes	Yes	No	HIV Positive	Yes	No
Swelling of feet/hands	Yes	No	Lung Problems	Yes	No	Hypoglycemia	Yes	No
Hepatitis A (inf)	Yes	No	Heart Surgery	Yes	No	Stroke	Yes	No
Herpes	Yes	No	Fever Blisters	Yes	No	Rheumatism	Yes	No
AIDS	Yes	No	Tuberculosis	Yes	No	Sickle Cell	Yes	No
IV Drug Use	Yes	No	Ulcers	Yes	No	Anemia	Yes	No
Psychosis	Yes	No	Artificial Joints/Hip	Yes	No	Heart Murmur	Yes	No
Emphysema	Yes	No	Date: _____			Pre-medicate?	Yes	No
(or other Respiratory Illness)			Pre-medicate?	Yes	No			

Height? _____ Weight? _____

Have you ever had any other serious illness not circled or mentioned above? If so, please describe: _____

Are you allergic to any medications? Please list: _____

MEDICATIONS— List all medications you are taking (include prescriptions, over-the-counter, herbal or natural products, vitamins, and drugs you take as needed, such as Tylenol).

Medication	Dose	Directions	Doctor Name	Reason for taking:

DOCTOR NOTES: _____

Reviewed by Doctor _____

Date _____

X _____
Patient Signature (Parent or Guardian)

Date