PATIENT INFORMATION SHEET PLEASE PRINT

Title: Mr. Mrs. Ms. Other: _____ First Name: _____ MI: _____ Last Name: _____

Nickname: _____ Sex: _____ Date of Birth: _____ Age: _____ Soc. Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Business Phone: (_____) _____ Physician: _____

Dentist: _____ Referred by: _____

Student: Full Time ❑ Part Time ❑ Not ❑ School Address: _____

Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ❑ Spouse's Name: _____

Employed: Full Time ❑ Part Time ❑ Retired ❑ Not Employed ❑ Employer Name: _____

Employer Address: _____

Who will be responsible for your account: Self ❑ Mother ❑ Father ❑ Other: _____

Name: _____ Social Security #: _____–_____–_____ Phone: _____

Address: _____ Employer: _____

Spouse: _____ Social Security #: _____–_____–_____ Phone: _____

Address: _____ Employer: _____

Employer Address: _____

Insurance Co.: _____ Subscriber's Name: _____

Address: _____ Address: _____

_____ _____

Phone: (_____) _____ Dental ❑ Medical ❑ Both ❑ Sex: _____ Subscriber's Date of Birth: _____

Group #: _____ Group Name: _____ Patient's Relation to Above: Self ❑ Child ❑ Spouse ❑ Other: ___

Insurance Co.: _____ Subscriber's Name: _____

Address: _____ Address: _____

_____ _____

Phone: (_____) _____ Dental ❑ Medical ❑ Both ❑ Sex: _____ Subscriber's Date of Birth: _____

Group #: _____ Group Name: _____ Patient's Relation to Above: Self ❑ Child ❑ Spouse ❑ Other: ___

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completions 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 at the top of the 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.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me. I recognize and accept personal responsibility for any balance or fee not covered.

Signature: _____ Date: _____ Signature: _____ Date: _____

(Of Insured) (Of Patient (18 & up))

I recognize and accept personal responsibility for any balance of fee not covered, regardless of the age of my natural born offspring or any person I may have adopted or have legal custody of possession.

Signature: _____ Date: _____

(Of Financial Responsible Party)

First Name: _____ MI: _____ Last Name: _____

Sex: _____ Date of Birth: _____ Age: _____

A. 1. Are you in good health? _____ Height: _____ Weight: _____

2. Have there been any changes in your general health in the past year? _____

3. Are you under the care of a physician? _____ Date of last visit: _____

4. Have you had any illness, operation or been hospitalized in the past five years? _____

_____

5. List any kinds of medicine, drug or pills you are taking: _____

_____

6. Do you have any allergies, or are you sensitive to any drugs such as: Penicillin, Novocaine, Aspirin, or Codeine? If so, please list:

_____

7. Is there any condition concerning your health or family's anesthetic history that the doctor should be told? Yes ❑ No ❑

B. **HAVE YOU HAD OR DO YOU CURRENTLY HAVE:**	Yes	No	Notes	**HAVE YOU HAD OR DO YOU CURRENTLY HAVE:**	Yes	No	Notes
1. Swollen ankles?	❑	❑		25. Thyroid trouble?	❑	❑	
2. History of endocarditis?	❑	❑		26. Diabetes?	❑	❑	
3. Heart valve replacement?	❑	❑		27. Kidney trouble?	❑	❑	
4. Fainting spells?	❑	❑		28. Are you on dialysis?	❑	❑	
5. High blood pressure?	❑	❑		29. Artificial joint replacement?	❑	❑	
6. Chest pain, angina?	❑	❑		30. Arthritis, joint disease?	❑	❑	
7. Heart attack(s)?	❑	❑		31. Stomach ulcers / GERD?	❑	❑	
8. Irregular heart beat?	❑	❑		32. Contagious disease?	❑	❑	
9. Cardiac pacemaker?	❑	❑		33. AIDS or HIV infection?	❑	❑	
10. Heart surgery?	❑	❑		34. Problems of the immune system?	❑	❑	
11. Bronchitis, chronic cough?	❑	❑		35. Cancer?	❑	❑	
12. Asthma?	❑	❑		36. Mental health problems?	❑	❑	
13. Hayfever/Sinus problems?	❑	❑		37. Are you wearing a removable dental appliance?	❑	❑	
14. Tuberculosis?	❑	❑		38. Use of street drugs or illegal drugs?	❑	❑	
15. Emphysema / Bronchitis / COPD?	❑	❑		39. Alcohol beverages?	❑	❑	
16. Difficulty breathing? Lung trouble?	❑	❑		40. Radiation therapy/Chemotherapy?	❑	❑	
17. Do you smoke?	❑	❑		41. Pain & clicking of jaws when eating?	❑	❑	
18. Sleep apnea?	❑	❑		42. Malignant hyperthermia?	❑	❑	
19. Blood disorder, such as anemia?	❑	❑		43. Are you taking birth control pills?	❑	❑	
20. Bleeding tendency (abnormal bleed)?	❑	❑		44. Possibility of pregnancy/ Are you nursing?	❑	❑	
21. Jaundice, hepatitis or liver disease?	❑	❑		45. List other medical conditions:			
22. Ever taken bone density medications?	❑	❑					
23. Convulsions, epilepsy?	❑	❑					
24. Stroke?	❑	❑					

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

1st Visit _____ DATE 2nd Visit _____ DATE 3rd Visit _____ DATE

Signature _____ Signature _____ Signature _____

Doctor _____ Doctor _____ Doctor _____