Deer Park Dental

Welcome

PATIENT INFORMATION

Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Cell. (_____) _____ Work (_____) _____ Home (_____) _____

Previous Dentist _____ Medical Doctor _____ Medical Doctor Tel. (_____) _____

Driver's Lic. # _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Employer _____ Bus. Tel. (_____) _____ Referred By _____

Occupation: _____ Personal hobbies: _____

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

Who will be responsible for your account?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

(If self, skip to next section)

Name _____ S.S. # _____ Birth Date _____ Age _____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

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

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY INSURANCE COMPANY

Insurance Type: ❑ Dental ❑ Medical

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

I.D. # _____ Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

SECONDARY INSURANCE COMPANY

Insurance Type: ❑ Dental ❑ Medical

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

I.D. # _____ Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

DENTAL INFORMATION

Chief complaint/concern: _____

Reason for today's visit: ❑ Exam ❑ Consultation ❑ Emergency Are you in pain? ❑ Yes ❑ No For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury / extraction
❑ Recent infections or sore throat
❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting

❑ Lost / broken filling(s)
❑ Teeth grinding / clenching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Toothache

❑ Stained teeth
❑ Locking jaw
❑ Bad breath
❑ Burning tongue / lips
❑ Difficulty in closing jaw
❑ Other: _____

❑ Difficulty in opening jaw
❑ Loose / shifting teeth
❑ Food caught between teeth
❑ Swelling / lumps in mouth

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard How would you rate your smile (worst) 1 2 3 4 5 6 7 8 9 10 (best)

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No Height _____ Weight _____ Are you under the care of a physician? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No Do you have dental anxiety? ❑ Yes ❑ No

Do you currently pre-med with antibiotic due to any type of prosthesis, total joint replacement, heart condition, and/or organ transplant? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Asthma	❑	❑	HIV / AIDS	❑	❑	Arthritis / Joint disease
❑	❑	Mitral valve prolapse	❑	❑	Hay fever / Sinus problems	❑	❑	Infectious mononucleosis	❑	❑	Stomach ulcers
❑	❑	Heart murmur	❑	❑	Snoring / Sleep apnea	❑	❑	Gallbladder trouble	❑	❑	Contagious diseases
❑	❑	High blood pressure	❑	❑	Respiratory problems	❑	❑	Fainting spells	❑	❑	Delay in healing
❑	❑	Low blood pressure	❑	❑	Tuberculosis	❑	❑	Convulsions / Epilepsy	❑	❑	Anemia
❑	❑	Chest pain / Angina	❑	❑	Emphysema	❑	❑	Stroke ❑ Date _____	❑	❑	Tumor or growth
❑	❑	Heart attack(s) ❑ Date _____	❑	❑	Blood transfusion	❑	❑	Thyroid trouble	❑	❑	Radiation / Chemotherapy
❑	❑	Irregular heart beat	❑	❑	Blood disorder	❑	❑	Diabetes	❑	❑	Are you on a diet
❑	❑	Cardiac pacemaker	❑	❑	Bruise easily	❑	❑	A history of alcohol abuse	❑	❑	Contact lenses
❑	❑	Heart surgery ❑ Date _____	❑	❑	A history of drug abuse	❑	❑	Sexually transmitted diseases	❑	❑	Immune system problems
❑	❑	Bronchitis / Chronic cough	❑	❑	Eye disease / Glaucoma	❑	❑	Swollen ankles	❑	❑	Malignant hyperthermia
❑	❑	Chronic fatigue / Night sweat	❑	❑	Abnormal bleeding	❑	❑	Organ transplant	❑	❑	Total artificial joints
❑	❑	Mental health problems	❑	❑	Bleeding tendency	❑	❑	Low blood sugar	❑	❑	Knee replacement
❑	❑	Damaged heart valves	❑	❑	Jaundice / Liver disease	❑	❑	Kidney trouble	❑	❑	Hip replacement
❑	❑	Are you immunosuppressed? *(possibly from transplant surg.)*	❑	❑	Hepatitis	❑	❑	Are you on dialysis			

MEDICATION AND ALLERGIES

Please list all medication(s) you are taking *(including natural, herbal, or homeopathic products)*: _____

_____

Are you now taking:

Y	N	
❑	❑	Nerve pills
❑	❑	Have you ever taken diet pills
❑	❑	Any bone density medication or Bisphosphonates *(Please circle which medication: Aredia, Zometa, Fosamax, Actonel)*
❑	❑	Have you ever taken Phen-Fen
❑	❑	Pain killers (including aspirin)
❑	❑	Tranquilizers
❑	❑	Natural/herbal supplements
❑	❑	Muscle relaxers
❑	❑	Aspirin
❑	❑	Insulin
❑	❑	Stimulants
❑	❑	Antidepressants
❑	❑	Blood thinners *(Please circle which medication: Coumadin, Aspirin, Advil, Motrin, Ibuprofen, Excedrin, Aleve, Plavix)*

Are you allergic to or had a reaction to:

Y	N	
❑	❑	Penicillin
❑	❑	Valium or other tranquilizers
❑	❑	Soy
❑	❑	Iodine
❑	❑	Local anesthetic (numbing med)
❑	❑	Codeine or other narcotics
❑	❑	Sulfites
❑	❑	Sulfa drugs
❑	❑	Aspirin
❑	❑	Eggs / Yolk
❑	❑	Sodium pentothal
❑	❑	Latex
❑	❑	Amoxicillin

Please list any other medication or antibiotic you are allergic to:

_____

Please list any allergies other than drug allergies: _____

_____

1-4 below for women only:

1) Is there a possibility of pregnancy ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

SOCIAL HISTORY

Smoker status:

❑ Current daily smoker
❑ Current occasional Smoker
❑ Former smoker ❑ Never smoked

Tobacco use:

❑ Current ❑ Former ❑ Never

Type of tobacco:

❑ Cigarette ❑ Smokeless ❑ Cigar
❑ Chewing ❑ Other: _____

Ever tried to quit:

❑ No ❑ Yes, year quit: _____

Other recreational drugs *(ie: marijuana)*

❑ No
❑ Yes *(frequency of use)* _____

I certify that I have read and I 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 doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: (Parent or Guardian if minor) **X** **Reviewed by:** **X** **Date:** **X**

FINANCIAL POLICY

Our practice is committed to offering you dental treatment of the highest quality. **Payment for services is due at the time that services are rendered.** Our relationship is with you and not your dental insurance. We will bill your dental insurance as a courtesy. **Any amount not paid by your insurance is your responsibility.**

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.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: (Parent or Guardian if minor) **X** **Date:** **X**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) **X** **Date:** **X**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: (Parent or Guardian if minor) **X** **Date:** **X**