Action Dental
We're Smiles Ahead!

Steven O. Peterson, D.M.D.
Complete Family Dentistry

Patient Information

Full Name: _____ ☐ Minor ☐ Single ☐ Married ☐ Divorced/Separated

Nick Name: _____ Address: _____ Zip:_____
City State

Birth date:_____ Age:_____ Height: _____ Weight: _____ SSN: _____

Home Phone: _____ Cell Phone _____

Employer: _____ Work Phone: _____

Health History

1. Are you currently being treated by a health care professional? ☐ Yes ☐ No
   If yes, please explain: _____
2. Have you ever been hospitalized or had any major operations? ☐ Yes ☐ No
   If yes, please explain: _____
3. Are you currently taking any drugs or medications? ☐ Yes ☐ No
   If yes, please list:_____
   _____
4. Are you allergic to any drugs or medicines (penicillin, aspirin, codeine, etc.)? ☐ Yes ☐ No
5. Do you have any know allergies to latex or metals (gold, silver, nickel, etc.) ☐ Yes ☐ No
6. Have you ever had a reaction from local anesthesia? ☐ Yes ☐ No
7. Have you ever had prolonged bleeding from an injury or previous extractions? ☐ Yes ☐ No
8. CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

☐ Heart failure	☐ Emphysema	☐ AIDS/HIV
☐ Heart Attack	☐ Cough	☐ Hepatitis type:_____
☐ Angina	☐ Tuberculosis	☐ Parkinson's Disease
☐ High Blood Pressure	☐ Asthma	☐ Gout
☐ Heart Murmur	☐ Hay Fever	☐ Digestive Disorders
☐ Rheumatic Fever	☐ Sinus Trouble	☐ Blood Transfusion
☐ Congenital Heart Lesions	☐ Allergies or Hives	☐ Hemophilia
☐ Artificial Heart Valve	☐ Diabetes	☐ Blood Diseases or Hemophilia
☐ Mitral Valve Prolapse	☐ Thyroid Disease	☐ Sexually Transmitted Diseases
☐ Heart Pacemaker	☐ Radiation or Chemotherapy	☐ Drug or Alcohol Addiction
☐ Arrhythmia	☐ Cancer or Tumors	☐ Epilepsy or Seizures
☐ Heart Surgery	☐ Arthritis	☐ Fainting or Dizzy Spells
☐ Artificial Joints	☐ Rheumatism	☐ Psychiatric Treatment
☐ Stroke	☐ Kidney Trouble	☐ Ulcers
☐ Sensory Impairment (hearing, sight, other)		☐ Tobacco Use

9. Have you had complications with any previous dental treatment? ☐ Yes ☐ No
10. When was your last dental exam? _____ X-Ray? _____ Cleaning? _____
11. Do you have any disease, condition, or problem not listed above? ☐ Yes ☐ No
    If yes, please explain:
12. **WOMEN**: Are you pregnant or nursing? ☐ Yes ☐ No

I have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware, and WILL INFORM YOU OF ANY FUTURE CHANGES. I will not hold Dr. Peterson responsible for any errors or omissions that I may have made in the completion of this form. I understand **there is no warranty or guarantee** as to any result and/or cure and that NO GUARANTEE HAS BEEN GIVEN ME that the proposed treatment will be curative and/or successful to my complete satisfaction due to individual patient differences. I understand I can ask for a full recital of all possible risks and costs attendant to my care by just asking. I hereby consent to the administration of local anesthesia with the risk of nerve injury and the dental treatment specified at this office.

Signature _____ Date _____ Reviewed _____
(If patient is a minor, signature of a parent/guardian is needed)

Insurance Information

Primary Insurance (if applicable):

Subscriber Name: _____ Home phone: _____ Cell phone_____

Birth date: _____SSN: _____ Relationship to patient: _____

Employer: _____ Work Phone: _____

Dental Ins. Company: _____Group #: _____ Policy/ID #: _____

Secondary Insurance (if applicable):

Subscriber Name: _____ Home phone: _____ Cell phone:_____

Birth date: _____SSN: _____ Relationship to patient: _____

Employer: _____ Work Phone: _____

Dental Ins. Company: _____ Group # _____ Policy/ID #: _____

Emergency Contact

Outside of Immediate Family Household

Name: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Address: _____

Person responsible for this account: _____ Relationship: _____

Address: _____ Home #: _____ Cell #:_____

How did you hear about our office? _____

I understand that payment for all dental treatment is due at the time of service. I understand that if I have dental insurance, my portion of the bill is due at the time of service. If I have insurance, I understand I am responsible for all remaining costs after the insurance has paid regardless of what the insurance company's estimated payment would be. If I do not pay the entire balance within twenty-five (25) days of the monthly billing date, there is a service charge of 1.75% per month which is an annual percentage rate of 21%. There is a minimum charge of $.50 per month. In case of default of payment, I promise to pay any legal interest on the balance due, together with any COLLECTION COSTS and ATTORNEY FEES incurred to effect collection of this account. I am aware that there is a $50 returned check fee, a $50 fee for missed or broken appointments (failure to give 24 hour notice during normal business hours), and a $50 record duplication fee (with a 2 week notice).

Consent for use and disclosure of Health Information

I have had full opportunity to read and consider the contents of this Consent and the Notice of Privacy practices. I understand that by signing this form, I am giving my consent to Action Dental for the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I also grant the right to release my dental/ medical histories and other information about my dental treatment to third party payor and/or health professionals.

Signature _____ Date _____
(If patient is a minor, signature of a parent/guardian is needed)