PATIENT INFORMATION FORM

DATE\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

FIRST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best # for contact; please check one

Mobil Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ \_\_ ]

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ \_\_ ]

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ext # \_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit/Apt\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Social Security Number\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Driver License Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status ( please circle one) Single Married Separated Divorced Widowed

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_

WE ARE PROVIDERS FOR THE MOST INSURANCE COMPANIES. IF YOU HAVE A QUESTION REGARDING YOUR INSURANCE OR YOUR FINANCIAL RESPONSIBILITIES, DO NOT HESITATE TO INQUIRE WITH OUR FRONT DESK STAFF PRIOR TO YOUR APPINTMENT.

RESPONSIBLE PARTY INFORMATION

(If patient is a responsible party for this account, you can skip this section)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ unit/apt\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

Date Of Birth \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Social Security Number\_\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

Driver License Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_ pg.1

WHOM MAY WE THANK FOR REFERRING YOU

INTERNET [ ] INSURANCE CO. [ ] DROVE BY [ ] MAIL [ ]

EXISTING PATIENT [ ] ( please provide the name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT:

ALL MAJOR CREDIT CARDS: VISA, MASTER CARD, DISCOVER, AMERICAN EXPRESS

DEBIT/ ATM CARDS

CARE CREDIT

CASH

CASHIERS CHECKS

MONEY ORDERS

SORRY, WE DO NOT ACCEPT PERSONAL OR BUSINESS CHECKS

PAYMENT IS EXPECTED IN FULL AT EACH APPOINTMENT.

INSURANCE INFORMATION

INSURANCE COMPANY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Name of the Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECONDARY INSURANCE (If secondary insurance is available, please provide information below. Failure to disclose insurance information constitutes an insurance fraud, a felony in the state of Nevada; NVCC1349.33)

INSURANCE COMPANY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST NAMES WITH WHOM YOU ALLOW US TO SHARE YOUR TREATMENT AND ACCOUNT INFORMATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ pg.2

PATIENT MEDICAL HISTORY

Are you under medical treatment now? YES NO

If YES, please list what kind \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for any surgery or serious illness? YES NO

If YES, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_\_

WOMEN ONLY:

Are you pregnant? YES NO

Is there any chance you might be pregnant? YES NO

Are you nursing? YES NO

Are you on any contraceptives? YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO THE FOLLOWING?

Antibiotics YES NO If YES, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Anesthetic YES NO If YES, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sulfa YES NO

Barbiturates YES NO

Sedatives YES NO

Iodine YES NO

Shellfish YES NO

Aspirin YES NO

Codeine YES NO

Metals YES NO

Latex YES NO

Hay Fever YES NO

Other YES NO. If YES, please list \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_,

\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? YES NO

If YES, how often? # of drinks\_\_\_/ day/ week/month

Do you use Controlled Substances? YES NO

If YES, please list what kind\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Opioids (pain medications) on the regular basis? YES NO

If Yes, please list what kind\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take Osteoporosis Medication? YES NO

If YES, what kind\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long\_\_\_\_\_\_ pg. 3

DO YOU HAVE/ HAD ANY OF THE FOLLOWING?

High Blood Pressure YES NO Past Present Controlled Not controlled

Low Blood Pressure YES NO Past Present Controlled Not controlled

Heart Attack YES NO When? \_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke YES NO When? \_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Pains YES NO Past Present Controlled Not controlled

Heart Disease YES NO

Night sweats YES NO Past Present

Cardiac Pacemaker YES NO Date of placement\_\_\_\_\_\_\_\_\_\_\_\_\_

Defibrillator YES NO Date of placement \_\_\_\_\_\_\_\_\_\_\_\_

Heart Murmur YES NO Past Present

Mitral Valve Prolapse YES NO

Angina YES NO

Rheumatic Fever YES NO

Fainting/ Seizures YES NO Past Present

Epilepsy/ Convulsions. YES NO Past Present

Cancer YES NO Past Present When diagnosed? \_\_\_\_\_\_\_\_

Radiation Therapy YES NO Past Present When received? \_\_\_\_\_\_ How long? \_

Chemotherapy YES NO Past Present When received? \_\_\_\_\_ How Long? \_\_

Diabetes YES NO Type\_\_\_\_\_\_\_ Controlled Not controlled

Kidney Disease YES NO

Thyroid Problem YES NO Controlled Not controlled

Asthma YES NO If Yes, do you use inhaler? YES NO How often? \_\_\_\_\_

Emphysema YES NO

Any autoimmune conditions YES NO If Yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis/ Jaundice YES NO Past Present

Ulcer/ Acid Reflex YES NO Past Present

Anemia YES NO Past Present

Easily wounded YES NO Past Present

Arthritis YES NO

Joint Replacement YES NO What joint? \_\_\_\_\_\_\_\_\_\_

Date of replacement? \_\_\_\_\_\_\_\_

What joint? \_\_\_\_\_\_\_\_\_\_\_

Date of replacement? \_\_\_\_\_\_\_\_

Breast Implants YES NO Date of placement? \_\_\_\_\_\_\_\_\_\_

Sexually Transmitted Disease YES NO What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Liver Disease YES NO

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you told to take antibiotics prior to dental appointments? YES NO

Were you advised by your physician of any precautions for dental appointment? YES NO

If Yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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MEDICATIONS

Please list all prescription and non-prescription medications that you are taking ( including vitamins and supplements)

NAME DOSAGE FREQUENCY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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AUTHORIZATION AND RELEASE

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that I have read, understood asked questions to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Initial \_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , authorize dentist and dental office staff to release any information including diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payers and/or health practitioners. Initial \_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize and request my insurance company to pay insurance benefits directly to the dentist or dental group otherwise payable to me Initial \_\_\_\_

I understand that my dental insurance carrier may pay less that actual bill of services.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to be responsible for the payment of all services rendered. Initial \_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and agree with 18% interest charge reoccurring on each 30-day term after initial bill. Account becomes delinquent in 180 days after initial bill. At that time, bill will be forwarded to the small claims court. That will carry $300 charge in addition to the pre-court amount of bill and court filing fees. Initial \_\_\_\_

Name of patient/ guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient/ guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

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