Patient Information

Patient Name: _____ Date:_____
Last First MI Preferred Name

Address:_____
Street Apartment #

_____
City State Zip Code

Employer: _____ Occupation: _____

Family Status: ☐ Married ☐ Divorced ☐ Single ☐ Child ☐ Other:_____

Social Security #:_____ Birth Date: _____ Gender: ☐ Male ☐ Female

Phone: Home _____ Work _____ ext.____ Cell: _____

Other: _____ Which number would you like us to use for appointment reminders? _____

Email Address: _____

I agree to receive emails from the practice ☐ Yes ☐ No

Spouse, Parent, or Responsible Party Information

The following is for: ☐ Spouse ☐ Patient's Parent/Guardian ☐ Person Responsible for Payment

Name: _____Employer:_____

Social Security #:_____ Birth Date: _____ Gender: ☐ Male ☐ Female

Phone: Home _____ Work _____ ext.____ Cell: _____

Address:_____

Insurance Information

Name: _____ Is subscriber a patient? ☐ Yes ☐ No

Subscriber Birth Date: _____ Social Security #:_____Group# _____

Subscriber's Address: _____

Subscriber's Employer/Address: _____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Co Name_____ Insurance Co Phone _____

Insurance Co Address _____

Consent for Services (Read Carefully)

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. **This office will help prepare the patients insurance forms or assist in making collections from the insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.**

A service charge of 1 1/2 % per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 30 days from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or my work or cell to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient _____
Signature of Patient, Parent, or Guardian

_____ Date: _____ Relationship to Patient _____
Signture of Guarnator of Payment/Responsible Party

How did you hear about our practice?

☐ Friend, relative, neighbor, etc. ☐ Another dentist ☐ Post Card ☐ Mailbox Flyer ☐ Internet ☐ Sign/Drive-by

So we may thank them, please provide name of person or dentist who referred you:_____

MEDICAL HISTORY Patient Name:_____ Date:_____

Please check all of the medical conditions/situations that apply to you.

- ☐ Heart Surgery
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Stent/Shunt
- ☐ Heart Pacemaker
- ☐ Sleep Apnea
- ☐ Rheumatic Fever
- ☐ Arthritis/Rheumatism
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Kidney Trouble
- ☐ Kidney Stent/Shunt
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ ↳ History of Bisphosphonates?
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Tumors
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Allergies or Hives
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Hepatitis A/B/C
- ☐ Headaches
- ☐ Venereal Disease
- ☐ HPV Diagnosis
- ☐ Cold Sores/Fever Blisters
- ☐ HIV Positive
- ☐ Glaucoma
- ☐ AIDS
- ☐ Blood Transfusion
- ☐ Blood Thinners
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Neurological Disorder
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervous/Anxious
- ☐ Psychiatric Care
- ☐ TMJ Disorder
- ☐ Smoke/Chew/Vape Tobacco
- ☐ Jaw/Ear Pain

Do you have any artificial joints? ☐ No ☐ Yes ➡ Please tell us which joint(s) and what year you got it/them _____

Do you have or have you had any disease, condition, or problem not listed above? ☐ No ☐ Yes ➡ Please list _____

Are you under the care of a physician? ☐ No ☐ Yes ➡ Please explain _____

Name of Physician _____

Are you taking any medication, drugs, or pills now? ☐ No ☐ Yes ➡ Please list _____

Are you aware of having an allergy (or adverse reaction) to any medication or substance? ☐ No ☐ Yes ➡ Please list _____

What is the reason for your visit today? _____

Date of Last Cleaning?_____ Date of Last Full Set of X-Rays?_____

Have you ever been diagnosed with periodontal "gum" disease? ☐ No ☐ Yes ➡ Date of treatment _____

What is your goal in seeking dental care? Please check all that apply

☐ Prevent problems ☐ Maintain current oral health ☐ Fix cosmetic problems ☐ Resolve pain only

WOMEN: Are you pregnant? ☐ No ☐ Yes ➡_____ Months Are you nursing? ☐ No ☐ Yes

Are you taking birth control pills? ☐ No ☐ Yes

Doctor Signature: _____

I understand that the information above is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____ (Patient Name)'s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutual agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication necessary. I fully understand that using anesthetic agents embodies certain risks; I understand that I can ask for a complete recital of any possible complications.

Patient _____ Date_____ Witness _____

Responsible Party _____ Relationship to Patient _____

Estero Bay DENTAL

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other(s)_____

☐ Information is not to be released to anyone.

This ***Release of information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number:_____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ leave a message asking me to return your call
- ☐ Other instruction: _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____