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Patient Information

Name: _____

Birthdate: _____ LAST FIRST MIDDLE _____

Sex: Male Female Marital Status: Married Single

Social Security #: _____ Driver's License #: _____ State: _____

Address: _____

Please provide all telephone numbers to contact you. There may be times when we need to reach you on short notice.

Home: _____ Work: _____ ext _____ Cell: _____

E-mail address (optional): _____ Other: _____

Is one of your immediate family members a patient here? Y / N Name: _____

How did you hear about us? _____

Primary Insurance

Insured's Name: _____

Social Security #: _____ LAST FIRST MIDDLE _____

Birthdate: _____ Insured's Employer: _____

Insurance Co.: _____ Group #: _____ Insurance Phone #: _____

Insurance Address: _____

Secondary Insurance (if applicable):

Insured's Name: _____

Social Security #: _____ LAST FIRST MIDDLE _____

Birthdate: _____ Insured's Employer: _____

Insurance Co.: _____ Group #: _____ Insurance Phone #: _____

Insurance Address: _____

Responsible Party Information:

Self: Y / N Other: _____

Relationship to Patient: _____ LAST FIRST MIDDLE _____

Birthdate: _____ SS #: _____ Driver's License #: _____

Address: _____

Home Phone: _____ Work Phone: _____

Emergency Contact Information:

Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Dental History

Do you require antibiotics before dental treatment? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you now or have you ever experienced pain <input type="checkbox"/> Y <input type="checkbox"/> N
Are you currently in pain? <input type="checkbox"/> Y <input type="checkbox"/> N	discomfort in your jaw joint (TMJ/TMD)?
Have you ever had a serious or difficult problem associated with <input type="checkbox"/> Y <input type="checkbox"/> N	any previous dental work? <input type="checkbox"/> Y <input type="checkbox"/> N
Your current dental health is <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Do you ever experience slow healing sores in your mouth? <input type="checkbox"/> Y <input type="checkbox"/> N
Do your gums bleed easily (e.g. when flossing)? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you participate in sports? <input type="checkbox"/> Y <input type="checkbox"/> N
How many times a week do you floss? _____	Do you use a protective mouthguard? <input type="checkbox"/> Y <input type="checkbox"/> N
How many times a day do you brush? _____	Have you ever experienced dental, oral or facial trauma? <input type="checkbox"/> Y <input type="checkbox"/> N
Are your teeth sensitive to heat, cold, or anything else? <input type="checkbox"/> Y <input type="checkbox"/> N	(e.g. a blow to the jaw)
Have you ever had gum/periodontal treatment? <input type="checkbox"/> Y <input type="checkbox"/> N	Are you interested in whitening your teeth? <input type="checkbox"/> Y <input type="checkbox"/> N
	Is there anything about the appearance of your teeth you would like to change? _____

Medical History

Do you have a personal physician? Y N
Physician's Name: _____
Phone #: _____
Date of last visit: _____
Your current physical health is: Good Fair Poor
Do you smoke or use tobacco in any form? Y N

Are you currently under the care of a physician? Y N
Please explain: _____
For Women: Are you taking a prescribed contraceptive? Y N
Are you pregnant? Y N Unsure Due Date: _____
Are you nursing? Y N

Have you ever had any of the following

HEART PROBLEMS

Heart attack Y N
Difficulty breathing Y N
Blood pressure problems Y N
Heart murmur Y N
Heart valve problems/ artificial valve Y N
Rheumatic/Scarlet fever Y N
Pacemaker Y N
Heart surgery Y N
Previous Endocarditis Y N

ALLERGY PROBLEMS

Hay Fever Y N
Sinus problems Y N
Asthma Y N

BLOOD PROBLEMS

Abnormal bleeding/bruising Y N
Blood disease (e.g. anemia) Y N

GASTROINTESTINAL

Ulcers/Colitis/Irritable Bowel Syndrome Y N
Kidney or bladder problems Y N
Other GI difficulties Y N

BONE OR JOINT PROBLEMS

Arthritis Y N
Back or neck pain Y N
Artificial bones or joints Y N

NEUROLOGICAL PROBLEMS

Fainting spells/ seizures/epilepsy Y N
Strokes Y N

Frequent headaches Y N

OTHER

Thyroid problems Y N
Cancer/Chemotherapy/ Radiation Y N
Diabetes Y N
Tuberculosis or other respiratory problems Y N
Alcohol/Drug Abuse Y N
Hepatitis/Jaundice/Liver problems Y N
STDs Y N
HIV+/AIDS Y N
Glaucoma/Other eye diseases Y N
Psychiatric problems Y N
Oral herpes/Fever blisters Y N
Autoimmune diseases Y N

Please list any other serious medical condition(s) that you have had: _____

Please list any medications (including over-the-counter or herbal supplements) you are currently taking or have taken in the previous 12 months: _____

Have you ever taken a bisphosphonate? (Usually used to treat osteoporosis and other degenerative bone diseases -- e.g. Boniva, Fosamax, Arridia) Y N

Are you allergic to any of the following?

Local dental anesthetics Y N Barbituates, sedatives, sleeping pills Y N Reactions to metals Y N
Penicillin or other antibiotics Y N Aspirin, Acetaminophen, Ibuprophen Y N Latex / Rubber Y N
Sulfa drugs Y N Codeine, Demerol, or other narcotics Y N Other: _____

Notice of Privacy Practices:

I have received a copy of this office's Notice of Privacy Practices. _____ Patient's Initials: _____

Financial Policy:

We bill insurance as a courtesy to our patients; however, patients are responsible for taking an active part in the recovery of their claim. Patients are financially responsible for any co-payments, deductibles, co-insurance and all charges not covered by insurance. Co-pays and deductibles will be collected at the time service is rendered. Because insurance benefits are determined when the claim is received, verification of benefits is not a guarantee of payment. Any balance remaining on the account after insurance has paid is the patient's responsibility. If the entire balance of the account is not paid within 30 days of receipt of insurance payment, a service charge of 18% will be added to the account per month. In the case of default payment, the patient is responsible for paying any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred. Patient Initials: _____

Broken Appointment Policy:

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so prevents our other patients from receiving needed dental care in a timely fashion. So that the dentist, our staff and our other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment (24 hours advance notification) will result in a \$75.00 fee being charged. That charge is to be paid prior to the scheduling of any new appointment. The patient is responsible for payment of the charge. Patient Initials: _____

Consent:

I have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my permission to Matheson Dentistry for use and disclosure of my protected health information to carry out treatment, payment, and health care operations. I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Patient's Signature: _____ Date: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

MEDICAL HISTORY UPDATE

OFFICE USE ONLY

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Patient's Signature: _____

Date: _____

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Patient's Signature: _____

Date: _____

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Patient's Signature: _____

Date: _____

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Patient's Signature: _____

Date: _____

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Patient's Signature: _____

Date: _____