CONFIDENTIAL PATIENT INFORMATION

GET ACQUAINTED QUESTIONNAIRE

Welcome to our office. We feel you will be pleased with the care you will be receiving. In order to begin treatment, the following Information is necessary. Please complete fully and PRINT legibly. All information will be held in strict confidence.

Thank you for joining our family of patients. FILE#

PATIENT HISTORY INFORMATION

PATIENTS first & last NAME__________ HOME PHONE __________

SOC. SEC. # __________ BIRTHDATE __________ AGE ______ SEX __________

ADDRESS __________ CITY __________ STATE ______ ZIP __________

PARENT'S NAME __________ WORK PHONE __________

PARENT'S NAME__________EMPLOYER__________

PERSON TO NOTIFY IN CASE OF EMERGENCY __________ PHONE__________

RELATIVE OR FRIEND NOT LIVING WITH YOU __________ PHONE __________

STUDENT: O FULL TIME O PART TIME SCHOOL __________ CITY __________

FAMILY MEMBERS:	AGE	LAST VISIT TO THE DENTIST
SPOUSE		
CHILD		
CHILD		
CHILD		
CHILD		

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR THE ACCOUNT __________

RELATIONSHIP TO PATIENT__________ HOME PHONE ______WORK PHONE__________

MAILING ADDRESS__________ CITY __________ZIP__________

SOC. SEC #__________ DRIVER'S LICENSE # __________

EMPLOYER__________ OCCUPATION __________

EMPLOYER'S ADDRESS__________ CITY __________ZIP__________

DENTAL INSURANCE

INSURED'S NAME__________

SS #__________ BIRTHDAY__________

EMPLOYER__________

INS. CO. OR PLAN__________

UNION/GRP. NAME__________

GRP. OR POLICY # __________LOCAL # __________

DATE EMPLOYED__________

SECONDARY INSURANCE O YES O NO

INSURED'S NAME

SS #__________BIRTHDAY __________

EMPLOYER__________

INS.CO OR PLAN__________

UNION/GRP. NAME __________

GRP. OR POLICY # __________LOCAL # __________

DATE EMPLOYED __________

PATINETS MEDICAL INSURANCE INFORMATION: __________

HOW DID YOU HEAR ABOUT US? __________

WHY ARE YOU HERE TODAY? O CHECK-UP O TOOTH ACHES O BRACES O CAPS

CONSENT TO FINANCIAL RESPONSIBILITY

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named Insurance carrier for purpose of claims administration and evaluation utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. Under HIPAA regulations I authorize my information to be disclosed to healthcare providers involved in my treatment and third party payers for obtaining payments. I have the right to restrict disclosure of my protected information.

I hereby authorize my Insurance Carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. I understand if my insurance company does not pay in full, I am responsible for the remaining balance. I understand some dental services I receive may require a co-payment from me. The amount of the co-payment may vary according to the insurance/dental plan I have and the procedure that is performed. If my insurance/dental plan has a yearly deductible, I understand it must be satisfied before treatment begins. I also understand co-payments must be paid in full at the time of treatment a finance charge of 1.5% per month (18% per annum) will be charged on the unpaid principal balance on all accounts not paid within 30 days of the date of service.

I further understand dental services not covered by my insurance/dental plan may be prescribed in certain cases by the attending dentists. Usual, customary and reasonable fees will be charged for such services.

I also understand there will be a charge for any missed appointment which is not cancelled 48 hours in advance.

RESPONSIBLE PARTY'S SIGNITURE__________ DATE __________

RELATION TO PATIENT __________

Does your child have or has had any of the following?

Yes	No		Yes	No		Yes	No	
O	O	Heart Murmur	O	O	Snoring	O	O	Allergies or Hives
O	O	Heart Surgery	O	O	Large Tonsils	O	O	Hepatitis or Jaundice
O	O	Pace Maker	O	O	Asthma	O	O	Thyroid Disease
O	O	Rheumatic Fever	O	O	Pneumonia	O	O	Tumors or Cancer
O	O	Bleeding Disorders	O	O	Tuberculosis	O	O	Chemotherapy or Radiation
O	O	Bruise Easily	O	O	Seizures	O	O	HIV or AIDS
O	O	Hemophilia	O	O	Head Injuries	O	O	Liver Disease
O	O	Blood Transfusion	O	O	Mental Disorder	O	O	Kidney Disease
O	O	Blood Pressure	O	O	Cerebral Palsy	O	O	Cold or Canker Sores

Does your child have any other problems you would like to share with us? ____________________

What is your child's regular doctor's name address and phone number ?____________________

When was the date of last check up?____________________

Has your child been hospitalized before?____________________

Has your child had any surgeries before?____________________

Has your child been to Emergency Room before?____________________

Is your child taking any medicines? ______ Reason for ?____________________

What are the name of the medicines?____________________

Does your child have any allergies to any drugs? () Latex () Penicillin () Sulfa () Codeine

If any other drugs, please name them____________________

DENTAL HISTORY

1. Has your child ever had a local anesthetic (Novocain, etc.)? ____________________
2. Has your child ever had any unfavorable reaction from a local anesthetic?____________________
3. Has there been any unfavorable experience associated with any previous dental treatment?__________
If so explain____________________
4. How long since your child's last full mouth x-rays? ____________________
5. How long since your last dental treatment?____________________
6. Are any current dental problems the result of any accidents? O YES ______ O NO______When?_____
7. Does dental treatment make your child nervous? O No O Slightly O Moderately O Extremely

To the best of my knowledge all the preceding answers are true and correct. If there are any changes to my child's health or his/her medications I will inform the Doctor A.S.A.P.

Signature of the Parent/Guardian: ____________________
Year 1 Change in Health: ____________________
Guardian's Signature ____________________Date:____________________
Year 2 Change in Health____________________
Guardian's Signature: ____________________Date____________________

DDS Notes: ____________________
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