PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: _____ Wireless Phone: _____

Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Recall: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Student status if dependent over 19 (for ins) ☐ Non Student ☐ Full Time ☐ Part Time

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: Self Spouse Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: Self Spouse Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:

_____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

Yes ☐ No ☐

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other allergies not listed above:

_____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Artificial Heart Valves	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	HIV / AIDS
☐	☐	Bleeding Problems / Blood Thinners	☐	☐	Joint Replacement
☐	☐	Cancer	☐	☐	Kidney Disease
☐	☐	Diabetes	☐	☐	Liver Disease
☐	☐	Drug Addiction	☐	☐	Pregnancy (Current)
☐	☐	Hepatitis B	☐	☐	Psychiatric Treatment
☐	☐	Hepatitis C	☐	☐	Stroke
			☐	☐	Ulcers

Other conditions not listed above:

_____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? _____

New Patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former Dentist: _____ City/State: _____

Date of last cleaning and exam: _____

NOTICE OF FINANCIAL AND PRIVACY POLICIES

Last Name: _____ First Name: _____ :

Birthdate: _____

For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
Treatment plans may change, and I will be responsible for the work actually done.
I will pay a fee for appointments broken without 24 hours notice.

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices (https://www.scottsborodentist.com/new-patient-paperwork).

I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Patient/Guardian Signature _____

Date _____