Medical Alert For Office Use

PATIENT REGISTRATION & HEALTH HISTORY FORM

Please complete the following confidential patient information so that we may make your visit pleasant and comfortable.

How Did You Hear About Our Office?
- ☐ Family/Friend (Name: ____________)
- ☐ Mailer
- ☐ Referral Brochure (If Yes, From Whom?____________)
- ☐ Building Sign/Drive-By
- ☐ Website/Web Search Engine
- ☐ Verizon Superpages (Erie County)
- ☐ Other (Please Explain: ____________)

Today's Date:

Patient's Name: Nickname: Birth Date: Age: Sex: M F

Street Address:

City: State: Zip:

Occupation: Emergency Contact:

Employer: Emergency Contact Phone #:

Employer Location: Driver's License #:

Phone: Home Social Security #:

Work May we contact you at work? Y N

Mobile Spouse's Name (or parent's if minor):

Email Address: Spouse's Employer (or parent's if minor):

Primary Dental Insurance

Subscriber Name: Social Security #: DOB:

Employer: Insurance Company:

Insurance Co. Phone#: Group #:

Relation to patient:

Secondary Dental Insurance

Subscriber Name: Social Security #: DOB:

Employer: Insurance Company:

Insurance Co. Phone#: Group #:

Relation to patient:

Insurance Authorization Statement (Please sign and date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs incurred during dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signed: Date:

If Patient is Under 18 Years of Age

Responsible Party: Relation to Patient:

Street Address:

City: State: Zip:

Phone #:

DENTAL HISTORY

Please check any of the following that apply to you.
- ☐ Currently experiencing dental pain/discomfort
- ☐ Sensitivity to cold, heat or sweets
  If yes, where? UR LR UL LL
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or filling breaking
- ☐ Grinding or clenching of teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath.

Do you have or have you had any of the following?
- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:
- Your last dental cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-rays _____ / _____

Name of Previous Dentist: ______________________________

Why did you leave? ______________________________

What did you like *most* about your last dentist? ________________

____

If you could whiten your teeth for a cost anyone could afford, would you do it? Y N

Do you smoke or use chewing tobacco? Y N
How much? How long?

If I could change my smile, I would:
- ☐ Make them whiter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored restorations
- ☐ Repair chipped teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale from 1 ---- 10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

What is your most important question or concern about your dental visit today?

MEDICAL HISTORY

Please check any of the following that apply to you.

☐ Abnormal Bleeding	☐ Diabetes	☐ Hemophilia	☐ Psychiatric Problems
☐ Alcohol Abuse	☐ Difficulty Breathing	☐ Hepatitis A	☐ Radiation Thearpy
☐ Allergies	☐ Drug Abuse	☐ Hepatitis B	☐ Rheumatic Fever
☐ Anemia	☐ Emphysema	☐ Hepatitis C	☐ Seizures
☐ Angina Pectoris	☐ Excessive Bleeding	☐ Herpes	☐ Sexually Transmitted Disease
☐ Arthritis	☐ Facial Surgery	☐ High Blood Pressure	☐ Shingles
☐ Artificial Heart Valve	☐ Fainting Spells	☐ Jaw Joint Pain	☐ Sickle Cell Disease
☐ Asthma	☐ Fever Blisters	☐ Jaundice	☐ Sinus Problems
☐ Blood Transfusion	☐ Frequent Headaches	☐ Joint Replacement	☐ Stroke
☐ Bruise Easily	☐ Glaucoma	☐ Kidney Problems	☐ Syhpilis
☐ Cancer	☐ Gonorrhea	☐ Liver Disease	☐ Thyroid Problems
☐ Chlamydia	☐ HIV/AIDS	☐ Low Blood Pressure	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Colitis	☐ Heart Murmur	☐ Pace Maker	
☐ Congenital Heart Defect	☐ Heart Surgery	☐ Pregnant (Currently)	

Do you have any of the following drug allergies?

☐ Aspirin	☐ Erthromycin
☐ Nitrous Oxide	☐ Valium
☐ Percodan	☐ Penicillin
☐ Local Anesthetic	☐ Sulfa
☐ Tetracycline	☐ Latex
☐ Codeine	☐ Other: ____________

Are you in currently under the care of a physician? If yes, explain.

____

Physician's Name: ______________________________

Phone: ______________________________

Please list any medications you are currently taking:

____

Treatment Authorization Form

I hereby authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or guardian, after thorough explanation and to be necessary and advisable, including any diagnostic aids deemed appropriate by the doctor and the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my dental health and medical condition. Payment for all services rendered are my responsibility.

Signature (Patient, Parent or Responsible Party): Relationship to Patient: Date:

Financial Agreement

All payments are due at the time services are started unless arrangements are made prior to treatment.

Insurance balances are ultimately the patient's obligation. We file (most) insurances at no cost to you as a courtesy. We are glad to offer this service. However, insurance balances that are not paid after 60 days may be billed directly to you.

Please keep your walk out statements and follow up with your insurance to ensure payment is in process.

Patient balances that go unpaid for 30 days or more may incur the following additional charges: Interest charges (1.5% per month or 18% APR), collection fees (up to 42% of the full balance), and/or legal charges.

Appointments not cancelled with a 24 hour notice, may result in a charge of $50.00 for reserved time.

A fee of $30.00 will be assessed for NSF check.

____

Signature of patient / guardian | Date

Patient and Responsible Party
Financial Information Agreement

Date: __________

Patient: ________________________________ **Age/DOB:** ____/ ______

Last name First name MI

____

Address City St Zip

Phone Day: ______________ **Evening:** ______________ **Email** ______________

SSN #: ______________ **Driver's Lic #:** ______________ **Male** or **Female** (please circle)

NOTE: If the Patient is the Responsible Party, you do not need to fill out duplicate information.

Responsible Party /Parent/Employee/Insured: ________________________________

Last name First name MI

SSN #: ______________ **Driver's Lic #:** ______________ **Age/DOB:** ____/ ______

____

Address City St Zip

Phone Day: ______________ **Evening:** ______________ **Email** ______________

Employer ______________ **Insurance? Y or N Carrier / PPO** ______________

By signing below, I authorize the release of this personal information to my insurance company or other interested parties, as needed. I also authorize the payment of benefits directly to G.C. Dental Arts *and I agree that the information listed is true and correct to the best of my knowledge. I further agree that should my insurance not pay for my claims within 45 days of filing, I will be responsible to pay the balance immediately and follow-up with my insurance company personally.*

____

Signature of Patient / Primary Insured / Parent or Legal Guardian, if a minor) **Date**

Patient Consent to receive Mail and/or Telephone Messages

____

Please Print (Last Name) (First Name) (M.I.)

Do we have your permission to:

Send a recall appointment reminder to your home? Y_____ N_____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y_____ N_____

I give permission to share appointment, billing or dental information with the person named below:

Name: ____

____ ____________________

Signature of Patient / Parent or Legal Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

____ ____________________

Signature of Patient / Parent or Legal Guardian Date