Patient Information (CONFIDENTIAL)

*Date*_____

*Title*_____ *Name*_____ *Preferred Name*_____

*Mailing Address*_____ *Physical Address*_____

*City*_____ *State*_____ *Zip*_____ *City*_____ *State*_____ *Zip*_____

*Home Phone*_____ *Cell Phone*_____ *Email*_____

*Employer*_____ *Work Phone*_____

*Birth Date*_____ *Age*_____ *SS#*_____

*If Student, Name of School*_____ *City*_____ *State*_____ ☐*Full* ☐*Part Time*

*Spouse/Parent Name*_____ *Employer*_____ *Work #*_____

*Person to Contact in Case of Emergency*_____ *Phone #*_____

*Whom may we thank for referring you?*_____

Responsible Party

*Name of Responsible Party*_____ *Relationship to Patient*_____

*Mailing Address*_____ *Physical Address*_____

*City*_____ *State*_____ *Zip*_____ *City*_____ *State*_____ *Zip*_____

*Home Phone*_____ *Cell Phone*_____

*Employer*_____ *Work Phone*_____

*Birth Date*_____ *Drivers License #*_____ *SS#*_____

Are you currently a patient in our office? ☐*Yes* ☐ *No*

Insurance Information

*Name of Insured*_____ *Relationship to Patient*_____

*Mailing Address*_____ *Physical Address*_____

*City*_____ *State*_____ *Zip*_____ *City*_____ *State*_____ *Zip*_____

*Home Phone*_____ *Cell Phone*_____

*Birth Date*_____ *Drivers License #*_____ *Work #*_____

*Employer*_____ *Since*_____ *SS#*_____

*Insurance Co*_____ *Group #*_____ *Policy/ID#*_____

*Mailing Address*_____ *Ins Co Phone #*_____

*City*_____ *State*_____ *Zip*_____

FEES AND PAYMENTS *(Fees are due in full at time of service)*

Please remember that insurance *is considered a method of reimbursing the patient for a portion of the fees paid to the doctor and are not a substitute for payment at time of service. If you present us with your insurance information, we will file a claim to them for your reimbursement once payment in full is received.*

I am aware that pre-authorization *and acceptance of submitted dental work to my insurance is not a guarantee of insurance payment.*

I authorize the dentist *to release any information, including the diagnosis and the records of any treatment of examination rendered to my family or me during the period of such dental care, to third party and/or health practitioners, by mail or electronic transmission, in accordance with the HIPAA Privacy Rule.*

I have read the office policies *as noted above for Specialists Dental Implant Center and I agree to be responsible for payment of all services and charges in this office rendered on my behalf or for other members of my family.*

*Patient/Responsible Party Signature*_____ *Date*_____

Patient Medical History

Patient Name_____

Are you ALLERGIC to, or have you had, any REACTIONS to the following? (please check Yes or No)

Y	N		Y	N	
☐	☐	Penicillin, Amoxicillin	☐	☐	Codeine or Other Pain Prescriptions
☐	☐	Clindamycin, Keflex, Cipro, Erythromycin	☐	☐	Aspirin (Advil), Ibuprofen, Acetaminophen (Tylenol)
☐	☐	Dental Anesthetics	☐	☐	Latex or Rubber Products
☐	☐	Metals (i.e. nickel, silver, gold, platinum, titanium)	☐	☐	Sulfa Drugs or Iodine
☐	☐	Barbituates, Sedatives (i.e. halcyon, valium)	☐	☐	Steroids or Cortisone
☐	☐	Other (drugs or foods)_____			

Are you taking any naturopathic (holistic) remedies, vitamins or herbal supplements? _____
Do you regularly take Rx blood thinners? _____ *Aspirin, Motrin, or Advil?* _____
Do you use controlled substances? _____ *Do you use tobacco or smoke?* _____
Are you under medical treatment now? _____
Have you been hospitalized for surgery or illness recently? _____
Have you had joint replacement surgery? _____ *What?* _____ *When?* _____
Has your physician or dentist suggested you be pre-medicated for dental work? _____ *What Rx?* _____
List any other prescription and non-prescription drugs you are regularly taking _____
_____
List all current Physicians _____

Women Only: Are you pregnant or think you may be pregnant? _____ *Approx Due Date* _____
Are you nursing? _____ *Are you taking oral contraceptives?* _____

Do you have, or have you ever had any of the following? (please check Yes or No)

Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Attack	☐	☐	High Blood Pressure	☐	☐	Radiation Therapy	☐	☐	Sexually Transmitted Disease
☐	☐	Heart Trouble	☐	☐	Low Blood Pressure	☐	☐	Chemotherapy	☐	☐	AIDS or HIV Infection
☐	☐	Angina/Chest Pain	☐	☐	Prolonged Bleeding	☐	☐	Arthritis	☐	☐	Hepatitis
☐	☐	Pacemaker	☐	☐	Anemia	☐	☐	Steroids/Cortisone	☐	☐	Jaundice
☐	☐	Mitral Valve Prolapse	☐	☐	Diabetes	☐	☐	Respiratory Problems	☐	☐	Fever Blisters, Herpes, Shingles
☐	☐	Artificial Heart Valve	☐	☐	Liver Disease	☐	☐	Asthma	☐	☐	Hay Fever, Allergies
☐	☐	Heart Murmur	☐	☐	Kidney Disease	☐	☐	Emphysema	☐	☐	Fainting, Seizures
☐	☐	Rheumatic Fever	☐	☐	Thyroid Problem	☐	☐	Tuberculosis	☐	☐	Stomach Troubles, Ulcers
☐	☐	Stroke	☐	☐	Cancer_____	☐	☐	Artificial Joint	☐	☐	Epilepsy, Convulsions
☐	☐	Glaucoma	Other_____								

Patient Dental History

*Name of previous Dentist*_____ *Location*_____ *Last Exam*_____

Do your gums bleed while brushing or flossing? _____
Are your teeth sensitive to hot/cold liquids/foods? _____
Are your teeth sensitive to sweet/sour liquids/foods? _____
Have you had any head, neck or jaw injuries? _____
Have you considered bleaching your teeth? _____
Have you bleached your teeth in the past? _____
Are you happy with your smile? _____
Have you considered replacing your silver fillings? _____
Have you had any orthodontic treatment? _____ *When?* _____
Do you wear dentures or partials? _____ *How long?* _____
Do you feel pain/discomfort in any teeth? _____ *Where?* _____
Do you have a dry mouth? _____
Have you experienced problems or pain in your jaw? _____
Do you have frequent headaches? _____
Do you clench or grind your teeth? _____
Do you wear/have you worn a nightguard? _____
Do you know/want to know about dental procedures available to improve your smile? _____

Patient Health Responsibilities

I have read and understand the above information to the best of my knowledge and realize that providing incorrect information can be dangerous to my health. I certify that the above questions have been accurately answered.

In order to achieve optimum results, a cooperative effort is required. Once a treatment plan has been established, it is the patient's responsibility to follow instructions provided involving follow up care and appointments. A mutual respect and consideration among the Doctors, patients and staff is required to achieve our common goals.

Patient/Guardian Signature_____ **Date**_____

Reviewed by Doctor _____ **Date** _____