

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 |
| <input type="checkbox"/> Penicillin, Amoxicillin | <input type="checkbox"/> Codeine or Other Pain Prescriptions |
| <input type="checkbox"/> Clindamycin, Keflex, Cipro, Erythromycin | <input type="checkbox"/> Aspirin (Advil), Ibuprofen, Acetaminophen (Tylenol) |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex or Rubber Products |
| <input type="checkbox"/> Metals (i.e. nickel, silver, gold, platinum, titanium) | <input type="checkbox"/> Sulfa Drugs or Iodine |
| <input type="checkbox"/> Barbituates, Sedatives (i.e. halcyon, valium) | <input type="checkbox"/> Steroids or Cortisone |
| <input type="checkbox"/> 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 |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> AIDS or HIV Infection |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Anemia | <input type="checkbox"/> Steroids/Cortisone | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Fever Blisters, Herpes, Shingles |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever, Allergies |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fainting, Seizures |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stomach Troubles, Ulcers |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Epilepsy, Convulsions |
| <input type="checkbox"/> Glaucoma | Other _____ | | |

Patient Dental History

Name of previous Dentist _____ Location _____ Last Exam _____

Do your gums bleed while brushing or flossing? _____ Have you had any orthodontic treatment? _____ When? _____

Are your teeth sensitive to hot/cold liquids/foods? _____ Do you wear dentures or partials? _____ How long? _____

Are your teeth sensitive to sweet/sour liquids/foods? _____ Do you feel pain/discomfort in any teeth? _____ Where? _____

Have you had any head, neck or jaw injuries? _____ Do you have a dry mouth? _____

Have you considered bleaching your teeth? _____ Have you experienced problems or pain in your jaw? _____

Have you bleached your teeth in the past? _____ Do you have frequent headaches? _____

Are you happy with your smile? _____ Do you clench or grind your teeth? _____

Have you considered replacing your silver fillings? _____ 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 _____