PATIENT INFORMATION-Please fill out form entirely

☐ **PLEASE CHECK BOX- IF YOU ARE A PREVIOUS PATIENT HERE OR FROM THE OLD LOCATION _____**

FULL NAME: _____

ADDRESS:_____ CITY:_____ST_____ZIP_____

HOME PHONE:_____WORK:_____CELL#:_____

E-MAIL ADDRESS:_____SEX____M____F MARITAL STATUS:_____

SOCIAL SECURITY #_____DATE OF BIRTH:_____AGE:_____

EMPLOYER:_____ NUMBER OF YRS. EMPLOYED:_____

SPOUSE/GUARDIAN: _____SOCIAL SECURITY # _____

DATE OF BIRTH:_____EMPLOYER:_____ WORK #_____

PRIMARY DENTAL INSURANCE (SELF): _____

SECONDARY DENTAL INSURANCE (SPOUSE): _____

REFERRED BY:_____MEDICAL DOCTOR:_____

EMERGENCY INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY:_____

PHONE#_____ RELATIONSHIP:_____

THE FOLLOWING INDIVIDUALS HAVE MY PERMISSION TO DISCUSS MY MEDICAL RECORDS, FINANCIAL ACCOUNT AND MY DENTAL TREATMENT.

NAME RELATIONSHIP PHONE_____

NAME RELATIONSHIP PHONE_____

DENTAL INSURANCE INFORMATION

IF DENTAL INSURANCE APPLIES: I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ANY INFORMATION AND FILE MY INSURANCE AND TO RECEIVE PAYMENT OF MY BENEFITS AS LONG AS I AM A PATIENT OF RECORD. ALTHOUGH THIS OFFICE FILES CLAIMS AS A SERVICE TO THE PATIENT, THE INSURANCE CONTRACT IS BETWEEN THE PATIENT AND THE INSURANCE COMPANY. YOUR OUT OF POCKET CO-PAY IS **ONLY** AN **ESTIMATION**, AS WE HAVE NO CONTROL OVER THE INSURANCE COMPANY'S METHOD OR AMOUNT OF PAYMENT, ANY DIFFERENCE IS ENTIRELY THE RESPONSIBILITY OF THE PATIENT/RESPONSIBLE PARTY.

DATE:_____ INITIALS:_____

METHOD OF PAYMENT

WHICH OF THE FOLLOWING WILL YOU BE USING? (FEES MUST BE PAID IN FULL AT THE COMPLETION OF TREATMENT.) ____ CASH_____CHECK_____VISA_____MC____DISCOVER ___AM EX____CARE CREDIT

IF I DO NOT PAY THE ENTIRE AMOUNT WITHIN 25 DAYS OF THE MONTHLY BILLING DATE, I GRANT PERMISSION FOR THE DOCTOR TO RELEASE ANY INFORMATION TO THE COLLECTION AGENCY. A FINANCE CHARGE OF .6875% PER MONTH, AN APR OF 8.25%, ON THE BALANCE THEN UNPAID AND OWED WILL BE ASSESSED EACH MONTH (IF ALLOWED BY LAW). IF MY ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY OR AN ATTORNEY FOR COLLECTIONS, I WILL PAY THE DOCTOR'S ATTORNEY FEES AND COLLECTION COSTS.

SIGNATURE;_____ DATE:_____

UPDATE WITHIN 6 MONTHS OF ORGINAL DOCUMENTS : _____ SIGNATURE : _____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

HEALTH HISTORY-Please fill form out entirely

The information you provide is for our records and will be considered confidential. In addition, it is your responsibility to update this medical history when any changes occur.

YES NO Have there been any changes in your general health within the past year?

YES NO HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST FIVE YEARS? REASON_____

YES NO HAVE YOU EVER RECEIVED THERAPY FOR ALCOHOLISM OR DRUG ADDICTION?

YES NO HAVE YOU EVER HAD ABNORMAL BLEEDING WITH PREVIOUS EXTRACTIONS, SURGERY, OR TRAUMA?

YES NO HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? PLEASE EXPLAIN_____

YES NO HAVE YOU HAD SURGERY (PAST 5 YEARS) PLEASE LIST _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING, (PLEASE CIRCLE):

DIABETES (TYPE_____)	ALLERGIES(SEASONAL)	ARTHRITIS
HIIGH BLOOD PRESSURE	ASTHMA	TMJ
HEART ATTACK/ STROKE(YR_____)	THYROID PROBLEMS	FREQUENT HEADACHES
BY-PASS-SURGERY (YR_____)	STOMACH ULCERS	EPILEPSY/SEIZURES
ANGINA	JAUNDICE	FAINTING SPELLS
MVP-HEART MURMUR	LIVER DISEASE	NERVOUS DISORDERS
PROSTHETIC HEART VALVE	HEPATITIS (TYPE_____)	PSYCHIATRIC CARE
CONGENITAL HEART DISEASE	HIV/AIDS	VENEREAL DISEASE
JOINT PROSTHESIS (HIP, KNEE)	KIDNEY INFECTIONS	CANCER (TYPE_____YR_____)
SMOKER_____PACKS/DAY_____	BLADDER INFECTIONS	DENTAL ANXIETY LOW-MED-HIGH
SINUS	RADIATION TREATMENT	HARD TO NUMB (NEVER-SOMETIMES-ALWAYS
PACEMAKER	LATEX ALLERGY	PANIC ATTACKS

YES NO DO YOU HAVE ANY JOINT REPLACEMENTS OR HEART CONDITION THAT REQUIRES ANTIBIOTICS PRIOR TO ANY DENTAL TREATMENT?
PRE MEDICATION TAKEN:_____TIME_____

YES NO ARE YOU UNDER THE CARE OF A DOCTOR FOR A CURRENT PROBLEM OR CONDITION NOT LISTED ABOVE: PLEASE SPECIFY:_____

YES NO ARE YOU TAKING MEDICINE ORAL OR IV FOR OSTEOPOROSIS (ARIDIA, ZOMETA, BONIVA, FOSAMAX, ACTONEL DIDRONEL, SKELID)?_START DATE_____STOPPED DATE_____

YES NO ARE ALLERGIC OR SENSITIVE TO ANESTHETICS, ANTIBIOTICS, IODINE OR OTHER MEDICATIONS?_____

WHAT MEDICINES ARE YOU TAKING FOR YOUR TOOTH?_____

_____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:_____

WOMEN:

YES NO ARE YOU PREGNANT?

YES NO ARE YOU NURSING?

YES NO DO YOU TAKE BIRTH CONTROL PILLS?

(IF YES, PLEASE BE ADVISED THAT IF YOU TAKE ANTIBIOTICS, AN ALTERNATIVE METHOD OF BIRTH CONTROL MUST BE USED.)

ALL OF THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. I GRANT PERMISSION FOR THE DOCTOR TO REQUEST/RELEASE ANY INFORMATION INCLUDING X-RAYS TO OTHER PROVIDERS AS NECESSARY REGARDING MY TREATMENT. ALSO PERMISSION IS GRANTED FOR ROOT CANAL TREATMENT, WHICH MAY BE NECESSARY OR ADVISABLE IN THE OPINION OF LARRY J. DURAND, D.M.D., MARK E. KALCHTHALER, D.M.D., AND DEREK A. GAUDRY, D.D.S. I ALSO AGREE TO HAVE BLOOD DRAWN IN THE EVENT OF A NEEDLE STICK ACCIDENT. I UNDERSTAND MY GENERAL DENTIST WILL COMPLETE THE FINAL RESTORATION. I ACKNOWLEDGE I HAVE RECEIVED A COPY (UPDATED TO MEET SEPT. 23, 2013 COMPLIANCE) OF THE "NOTICE OF PRIVACY PRACTICES RIGHTS" HIPAA/PHI AND MY QUESTIONS HAVE BEEN ANSWERED. I GIVE AUTHORIZATION TO RELEASE WORK/SCHOOL EXCUSES W/ ANY MEDICAL RESTRICTIONS. I ALSO UNDERSTAND AND GRANT PERMISSION FOR THE DOCTORS AND/OR STAFF TO CONTACT MYSELF AND/OR LEAVE A MESSAGE AT/ON E-MAIL, CELL, HOME OR PLACE OF EMPLOYMENT PERTAINING TO MY DENTAL CARE/FINANCIAL ACCOUNT OR APPOINTMENTS.

****PATIENT SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS UNDER THE AGE 18)

_____ _____

DATE SIGNATURE*