

Patient Information

Patient Name _____ Date _____

Last First Middle (Preferred Name)

Social Security # _____ Birthdate _____

Phone: Home _____ Work _____ Ext: _____ Best time to call _____

Address: _____

Street Apartment #

City _____ State _____ Zip Code _____

In case of emergency, whom should be notified _____ Phone _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name _____

Last First Middle (Preferred Name)

Male Female Married Single Child Other

Social Security # _____ Birthdate _____

Phone: Home _____ Work _____ Ext: _____ Best time to call _____

Address: _____

Street Apartment #

City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient's spouse the person responsible for payment

Employer Name _____ Occupation _____

Address _____

Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured _____ Is insured a patient? Yes No

Last First Middle (Preferred Name)

Insured's Birthdate _____ ID# _____ Group# _____

Insured's Address _____

Street City State Zip Code Phone

Insured's Employer Name _____

Address _____

Street City State Zip Code Phone

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name and Address _____

Secondary

Name of Insured _____ Is insured a patient? Yes No

Last First Middle (Preferred Name)

Insured's Birthdate _____ ID# _____ Group# _____

Insured's Address _____

Street City State Zip Code Phone

Insured's Employer Name _____

Address _____

Street City State Zip Code Phone

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name and Address _____

Orange Family Dentistry

Medical History

List any medications that you are currently taking:

Medications	Quantity	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently under medical treatment? Yes No

Please explain _____

Treating Physician _____

Have you had any of the following?

- | | | | |
|---|------------------------------|-----------------------------|---------------------------------|
| Heart Surgery, Disease, Attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How is it controlled? _____ |
| Pain in your Chest or shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Mitral Valve Prolapse (dysfunction) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Artificial Heart Valve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| Arthritis/Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Cortisone Medicine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Swollen Ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Anemic | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Are you subject to fainting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Are you subject to dizziness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How is it controlled? _____ |
| Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Kidney Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Yellow Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Contact Lenses | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Artificial Joints or Hip | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Allergic to any medications or drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | What? _____ |
| Asthma, Hay Fever or Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Latex Sensitive | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Sinus Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Tonsil or adenoid problems or surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Tumor or Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How was it treated? _____ |
| Major Operation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | What for? _____ |
| Significant Weight Change in last year | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Loss _____ lbs. Gain _____ lbs. |
| Diet Medically Supervised | <input type="checkbox"/> Yes | <input type="checkbox"/> No | For what purpose? _____ |
| Vitamin or Mineral Supplements | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Fatigue Easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Sleep Well | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Snore | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Trouble Breathing When Asleep | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Sleep with Bed Elevated | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Frequently Do Not Eat Breakfast | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

Have you had any of the following - continued

- More than one alcoholic drink per day Yes No How many? _____
- Smoke or Use Tobacco Yes No
- Radiation Therapy Yes No
- Chemotherapy Yes No
- Venereal Disease Yes No
- A.I.D.S. Yes No
- H.I.V. positive Yes No
- Blood Transfusion Yes No
- Hemophilia Yes No
- Sickle Cell Disease Yes No
- Bruise Easily Yes No
- Nervous Disorder Yes No
- Neurological Disorder Yes No
- Epilipsy or Seizure Yes No
- Fainting or Dizzy Spells Yes No
- Nervous or Anxious Yes No
- Psychiatric Care Yes No
- Do you sleep with more than 1 pillow? Yes No

For Woman (optional):

- Are you pregnant? Yes No Expected delivery date _____
- Do you have any history of previous miscarriages? Yes No
- Ovulate Regularly Yes No
- Have you reached menopause? Yes No List supportive medications _____
- Have you had a hysterectomy? Yes No
- Have you been diagnosed with PMS? Yes No
- Do your nails break easily? Yes No
- Does cold weather bother you? Yes No

Please write in any other pertinent information that has not been covered previously? _____

How did you hear about our office? _____

AUTHORIZATION: I hereby authorize the doctor and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedure as may be necessary for proper dental care. The information which appears on these medical and dental histories is correct to the best of my knowledge. I also authorize the doctor and/or staff to contact my health care giver(s) concerning my treatment if necessary.

Signature of Patient _____ Date _____

Orange Family Dentistry

Office Policies

We do our best to see you at the appointed time. Please help us stay on schedule by arriving on time. If unable to keep an appointment, kindly give 24 hours notice so that we may have the opportunity to see another patient in need of care. You may be charged for the time if proper notice is not received.

Guarantors are responsible for payment of services rendered.

Patients are responsible for checking with their insurance for what services are covered and for deductibles.

The guarantor of accounts will also be responsible for fees charged by collection agencies, attorneys, and court costs if they are required for collection of this account.

A service charge of 1.5 percent per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

All accounts 90 days past due will AUTOMATICALLY be turned over to collections.

RELEASE AND ASSIGNMENT: I hereby authorize the release of any information, including the diagnosis and records and any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating billing and reimbursement, directly to the doctor, of insurance benefits to which I am entitled.

Signature of Patient _____ Date _____