PATIENT INFORMATION FORM

PATIENT (Last,First,MI)________________________________PREF________________

HOME ADDRESS____
(street) (city) (state) (zip)

DATE OF BIRTH____/_____/______ SS#______-_____-_______ SEX: M / F STATUS: Single/ Married/ Divorced/ Widowed

HOME PHONE____________________WORK PHONE____________________CELL ____________________

______________________________________ PARENT/GUARD DOB ________________
IF PATIENT IS MINOR, PARENT/GUARDIAN NAME

EMAIL ADDRESS____

EMERGENCY CONTACT ______________________________ PHONE ________________

PRIMARY DENTAL INSURANCE

Subscriber Name ____DOB________________

Address: ____City ________________
If different than above address
State: ________Zip: ______________Phone: ____________________Relationship to patient:________________

Ins company: ______________________________Member ID: ____________________

Group Name/Employer:______________________________Group #:________________

Ins phone: ______________________

SECONDARY DENTAL INSURANCE

Subscriber Name____DOB________________

Address: ____City ________________
If different than above address

State: _______Zip: ____________Phone: ____________________Relationship to patient: ________________

Ins company: ______________________________Member ID: ____________________

Group Name/Employer:______________________________Group #:________________

Ins phone: ______________________

☐ NO DENTAL INSURANCE AT THIS TIME

Premier Dentistry of Christiana

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL CLAIMS. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT THE ABOVE INFORMATION IS GIVEN FOR THE PURPOSE OF OBTAINING CREDIT, AND I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE, AS OF THE DATE OF THIS APPLICATION. I GIVE MY PERSONAL GUARANTEE FOR ALL CHARGES INCURED.

______________________________________ ____________________
PATIENT /PARENT/GUARDIAN SIGNATURE DATE

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HEALTH HISTORY
PLEASE CHECK ALL THAT APPLY

- ☐ AIDS
- ☐ ALLERGY – CODEINE
- ☐ ALLERGY – ERYTHRO
- ☐ ALLERGY – HAY FEVER
- ☐ ALLERGY – LATEX
- ☐ ALLERGY – OTHER
- ☐ ALLERGY – PENICILLIN
- ☐ ALLERGY – SULFA
- ☐ ALLERGY –ASPIRIN
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ CANCER
- ☐ CHOLESTEROL
- ☐ DIABETES
- ☐ DIZZINESS
- ☐ EPILEPSY
- ☐ EXCESSIVE BLEEDING
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ HEAD INJURIES
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV
- ☐ JAUNDICE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ MENTAL DISORDER
- ☐ NERVOUS DISORDER
- ☐ NKDA
- ☐ OTHER ________________
- ☐ PACEMAKER
- ☐ PRE MED – AMOX
- ☐ PRE MED – CLIND
- ☐ PRE MED – OTHER
- ☐ PREGNANCY
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATISM
- ☐ SINUS PROBLEMS
- ☐ STOMACH PROBLEMS
- ☐ STROKE
- ☐ THYROID
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ ULCERS
- ☐ VENEREAL DISEASE

LIST ANY ALLERGIES ____

____

LIST OF MEDICATIONS ____

____

____

CURRENTLY PREGNANT? YES DUE DATE _____/_____/_____, NO

OTHER CONDITION ________________________________

HAVE YOU EVER HAD ANY COMPLICATIONS FOLLOWING ANY DENTAL TREATMENT? YES NO

IF YES, PLEASE EXPLAIN ____

____

____

HAVE YOU BEEN HOSPITALIZED OR NEEDED ANY EMERGENCY CARE DURING THE PAST 2 YEARS? YES NO

IF YES, PLEASE EXPLAIN ____

____

____

ARE YOU UNDER THE CARE OF A PHYSICIAN CURRENTLY? YES NO

IF YES, PLEASE EXPLAIN & LIST NAME OF PHYSICIAN ________________________________

____

____

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APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:
We require that you give **2 business day's** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that time slot. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $45** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be made without payment of this fee.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify those questions for you.
We thank you for your patronage.

I have read and understand the *Appointment Cancellation Policy* of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended at any time by the practice; with or without notice.

I, ____ have read a copy of the **Premier Dentistry of Christiana**
(Printed Patient Name)
Appointment Cancellation Policy.

____ ________________
Patient or Responsible Party Signature Date

CONSENT FOR SERVICES

We are complimented that you have selected us to provide dental care for you. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medications and therapy

indicated for such treatment in connection with ____. I understand that using
(Printed Patient Name)
anesthetic agents embodies a certain risk. Further-more, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a one and a one half percent monthly finance charge (18% APR) will be added to my account, and I agree to pay it. I understand and agree that where appropriate, credit bureau reports may be obtained.

____ ________________
Patient or Responsible Party Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________, have read a copy of this office's Notice of Privacy Practices.
Patient Name

______________________________ ______________
Patient or Responsible Party Signature Date

If this Ackowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name ______________________________

Relationship to Patient ______________________________

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify) ______________________________

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