Bucktown Dental Associates

Today's Date _____

PATIENT'S INFORMATION

Patient Last Name _____ First Name _____ Date of Birth _____

Home Address _____ City & Zip Code _____

Home Phone _____ Cell Phone _____

Email address _____ Social Sec No. _____

How did you hear about our office:

Internet ☐ Outer sign ☐ Insurance ☐ Other _____

PERSON RESPONSIBLE FOR THE ACCOUNT

Name _____ Social Security Number _____

Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell _____ Work _____

Email _____

INSURANCE INFORMATION

Name of Insurance _____

Name of Insured _____ Relationship to Patient _____

Social Security Number _____ Date of Birth _____

Address of Insured _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Employer _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my Insurance, address, and/or phone number.

I authorize the dentist & staff to take x-rays, administer local anesthetics, and perform any services needed during diagnosis & treatment. The dentist and staff will provide the best dental care possible. However, no guarantee can be made as to the success of treatment.

I authorize the office to release information to insurance companies and third-party payers. I also authorize the insurance companies and third party payers to send payments directly to the dentist. I understand that I am fully responsible for payment of all services. I also understand that an adult accompanying a minor is responsible for the account. Payment is due at the time of service unless other arrangements have been made with the office.

If my insurance company has not paid my account in full within 60 days, the balance will be transferred to my account. A 1.5% monthly administrative fee and $5 billing fee will be added to balances not paid in 30 days.

If account is not paid within 90 days of service and no financial arrangements have been made, I understand that I will be responsible for legal and collection fees in addition to interest and all other expenses incurred in collecting my account. The office may delay or forego enforcing any of its rights or remedies without losing them.

I acknowledge that I was provided with a copy of Notice of Privacy Practices (posted in waiting area and on the office website.)

Name of person filling this form _____ **Signature** _____

HEALTH HISTORY

How long since your last dental exam? _____

When was the last time you had your teeth cleaned? _____

Purpose of your visit today _____

Do your gums bleed or hurt?_____ **Yes** **No**

Are any of your teeth sensitive to Hot ☐ Cold ☐ Sweets ☐ Pressure? ☐

Do you feel your breath is offensive at times?_____ **Yes** **No**

Are You Taking any of the following:

1. Recreational drugs?	Y N	3. Tobacco in any form?	Y N
2. Medications, over the counter medicines?	Y N	4. Alcohol?	Y N

List: _____

_____

Are you allergic to any of the following:

5. Latex	Y N	8. Asprin	Y N
6. Penicillin or other antibiotics ----------	Y N	9. Ibuprofen	Y N
7. Local anesthetics	Y N	10. Other medications	Y N

Do You Have or Have You Had:

11. Bleeding problems, bruising easily?	Y N	23. VD (syphilis or gonorrhea)?	Y N	_____
12. Heart attack, heart defects?	Y N	24. HIV/AIDS	Y N	
13. Heart disease?	Y N	25. Hepatitis, other liver disease?	Y N	_____
14. Heart murmurs?	Y N	26. Kidney, bladder disease?	Y N	
15. Rheumatic fever?	Y N	27. Thyroid, adrenal disease?	Y N	_____
16. Pacemaker?	Y N	28. Artificial joint?	Y N	
17. Prosthetic heart valve?	Y N	29. Stomach problems, ulcers?	Y N	_____
18. High blood pressure?	Y N	30. Anemia?	Y N	
19. Stroke, hardening of arteries?	Y N	31. Tumors, cancer?	Y N	_____
20. Diabetes?	Y N	32. Radiation treatments?	Y N	
21. Family history of diabetes?	Y N	33. Chemotherapy?	Y N	_____
22. Asthma?	Y N	34. TB, or lung disease?	Y N	

Women Only

35. Are you or could you be pregnant?	Y N	37. Taking birth control pills?	Y N
36. Are you nursing?	Y N		
