Patient Information Form

Please tell us how you referred to our office____

Name ____________________________ __________________________ _____ ________________________
Last *First* *MI* *Preferred*

Birthday _________________ **SS#** __________________ **Marital Status** S M D

Gender ___ **M** ___ **F** **Driver's License State** ____ **DL#** _____________________________

Address

____ _________________________ ______ ______________
Street *City* *State* *Zip*

Mailing Address if Different from Above

____ _________________________ ______ ______________
Street *City* *State* *Zip*

Preferred contact method (circle one)? *Home Phone* *Cell Phone* *Work Phone* *Text* *Email*

Phone Numbers: **Cell** ____________________ **Home** ____________________ **Work** ____________________

Email Address: ____

Parent / Legal Guardian Information (If patient under 18years of age)

Name ____________________________ __________________________ _____ ________________________
Last *First* *MI* *Preferred*

Gender ___ **M** ___ **F** **Driver's License State** ____ **DL#** _____________________________

Relationship to Patient ____

Birthday _________________ **SS#** __________________ **Marital Status** S M D

Emergency Contact Information

Name ____________________________ __________________________ _____
Last *First* *MI*
Relationship to Patient ____

Phone Numbers: **Cell** ____________________ **Home** ____________________ **Work** ____________________

Email Address: ____

Dental Insurance Information

Primary Insurance Company ________________________________

Relationship to Subscriber (Circle One) Self / Spouse or Life Partner / Child

Insurance Company Phone# __________________

Subscriber Name ____________________________ __________________________ _____
Last *First* *MI*

Subscriber Birthdate (MM/DD/YY) _______________

Subscriber I.D# or SS#_____________________

Employer ________________________________ **Group Name** _____________**Group#**________

Financial Information

-For my convenience, Platteville Family Dentistry may release my information to my insurance company and receive payment directly from them.

-I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.

-If sent to collections, I agree to payt all related fees and court costs.

-Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.

-I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.

-I will pay a fee for appointments broken without 24 hours notice.

-Treatment plans may change and I will be responsible for the work actually done.

Privacy Policy

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Appointment Policy

Dr. Dorian, her Associates, and her staff take your time very seriously and try their best to accommmodate your schedule. The staff makes every effort to see you on time. **Please note that it is required to give a minimum of 24 hours notice for re-scheduling or canceling your appointment. Otherwise, you will be subject to a $50 fee per hour missed. We appreciate your courtesy!**

____ __________________________

Signature **Date**

HEALTH HISTORY

Date of last health care exam: ________________ What was the exam for?: ________________________________

Have you been hospitalized in the last 5 years? (please circle) No Yes
If yes, reason: ____

Are you currently under the care of a physician? (beyond routine physicals) (please circle) No Yes
If yes, please describe nature of care: ____

Do you have a chronic condition or recurrent illness? No Yes
If yes, please describe: ____

Please list the names and phone numbers of the physicians who are currently providing you care:

____
____
____

Have you had or do you have:

Heart valve replacement or other heart surgery	No	Yes	Cold sores (oral herpes) or canker sores (aphthous ulcers) in mouth	No	Yes
Heart disease/ Abnormal heart condition	No	Yes	Joint Replacement	No	Yes
Family history of heart disease	No	Yes	HIV or AIDS	No	Yes
Diabetes	No	Yes	Glaucoma	No	Yes
Family history of diabetes	No	Yes	Abnormal bleeding	No	Yes
Liver Disease (including jaundice)	No	Yes	Epilepsy/Seizures	No	Yes
Kidney Disease	No	Yes	Hepatitis (any form)	No	Yes
Asthma	No	Yes	Cancer	No	Yes
Emphysema or other lung condition	No	Yes	History of radiation or chemotherapy	No	Yes
Autoimmune disease	No	Yes	Sinus problems	No	Yes
Acid Reflux	No	Yes	Psychiatric care	No	Yes
Osteoporosis	No	Yes	Chronic pain condition	No	Yes

Has another dentist or physician recommended that you take antibiotics prior to dental treatment? No Yes

Women:
Are you currently pregnant?
If no, are you planning a pregnancy in the near future?
Are you a nursing mother?
Are you taking birth control pills?

Allergies:
Are you allergic to, or have you had a reaction to, or have you been told you should not take:

Latex	Local anesthetics	Oxycodone (Percocet)
Aspirin	Ibuprofen	Valium or other sedatives
Codeine	Hydrocodone (Vicodin/Lortab)	Penicillin or other antibiotic ________________

Blood Pressure:
Do you have abnormal blood pressure? No Yes
If yes, what is a typical reading: _______systolic _______diastolic

Drugs/Medications/Supplements:
Are you a current tobacco user? No Yes
If no, are you a former tobacco user? No Yes
How long ago did you quit? ______________
Circle form of tobacco: cigarettes chewing tobacco
For smokers, how much do/did you smoker per day?: ____________________

Do you routinely use recreational drugs? No Yes

Do you regularly consume alcohol? (more than two drinks per day?) No Yes

Please list any medications you are currently taking:

_____________________________ _____________________________ _____________________________
_____________________________ _____________________________ _____________________________

Do you take injectable or oral Bisphosphonates*?: No Yes
*(*common names Fosamax, Boniva, Actonel, Atelvia, Reclast)*

Are you taking Tagament (Cimetindine)?: No Yes If yes, how often?: ______________________
Do you take antacids? No Yes If yes, how often?: ______________________
Are you taking any herbal supplements or vitamins? No Yes If yes, which ones?: ______________________

Diet:
Refined sugar in your diet: None ☐ Slight ☐ Moderate ☐ High ☐

Do you consume grapefruits, grapefruit juice, or grapefruit extract? No Yes

Food allergies?: ____

Dental History:
Are you currently in pain? No Yes If yes, rate your current pain on a scale of 1-10 (10 is the worst): _____

Do you have a specific dental problem? No Yes If yes, describe ____

Do you have dental cleanings and examinations on a routine basis? No Yes Last Visit? ________________

Status of your current dental health to the best of your knowledge (circle one): Excellent Good Fair Poor
Comments ____

Do you think you have active tooth decay or gum disease? No Yes

Do you brush and floss on a routine basis? No Yes Frequency ____________________________

Have you had a bad experience in a dental office? No Yes
If yes, please describe: ____

Do you want to keep your remaining teeth? No Yes comments: ____________________________________

Do you ever grind your teeth at night, or wake up with a sore jaw or headache?: No Yes

Do you notice popping or clicking of your jaw?: No Yes

Have you ever had orthodontic treatment? (braces, or other means of tooth straightening): No Yes

If known, describe the dental status of your parents:

Mother ____

Father ____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of change in my health and medication.

___________________________ ___________________________ ___________________________
Patient (Print Name) Patient Signature (or guardian if patient is under 18) Date

___________________________ ___________________________ ___________________________
Doctor/Hygienist (Print Name) Doctor /Hygienist Signature Date