PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name: ________________ Date of Birth:__________ ☐ Male ☐ Female
Last First Initial

If Child, Parents' Names :________________ Age:__________

How do you wish to be addressed:________________

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Home Phone: ________________ Work Phone: ________________

Cell Phone#:________________ E-Mail: ________________

Mailing address: ________________

City: ________________State: ________ Zip: ________________

Patient/Parent Employed By:________________

Present Position:________________

Spouse Name: ________________

Spouse Employed By: ________________ Present Position: ________________

Patient/Parent Social Security No:________________

Spouse Social Security No:________________

Parent/Patient Drivers License No:________________

Someone to notify in case of emergency not living with you:________________

Purpose of Appointment: ________________

Other Family Members in this Practice: ________________

Whom may we thank for referring you to our office? ________________

BILLING, CREDIT, AND INSURANCE INFORMATION:

☐ Not covered by dental insurance

Method of Payment: Insurance ☐ Cash/Check ☐ Credit Card ☐

Who is Responsible for this account: ________________ Date of Birth:________________

Relationship to patient: ________________ Employer Name:________________ Yrs.:________

Name of Dental Insurance Co.________________

Address:________________

Telephone No: ________________

Program or Policy #: ________________ Group number:________________

Member ID:________________ Insured Social Security No: ________________

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.I consent to the dentist's use and discloser of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

____

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE.

____ Date: ______________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect, heart disease
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure (please circle)
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?
- ❑ Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?
- ❑ Do you habitually use controlled substances?
- ❑ Have you had psychiatric treatment?
- ❑ Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:______________________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:______________________________
____

Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) ☐ Yes ☐ No

Are you under a physician's care?: ☐Yes ☐No

Since when: ______________________________

Why: ______________________________

When was your last physical exam?: ____________________

Would you like to speak to the Doctor privately about any problem?: ☐ Yes ☐ No

Women:

- ❑ May be pregnant
  Expected delivery date: ____________
- ❑ Taking hormones or contraceptives

Name of your physician:______________________________ Physician Telephone: (____)______________________

Please list any medications or substances you are taking: ______________________________

____

Are you allergic to any medications or substances? (please list):

____

____

Do you have any disease, condition, or problem not listed above?______________________________

____

Please add anything else you would like us to know about:______________________________

____

Signature of patient (or parent) ______________________________ Date ______________

Dental History

- Purpose of initial visit: ______________________________
- Are you aware of a problem? ______________________________
- How long since your last dental visit?: ______________________________
- What was done at that time?: ______________________________
- When was the last time your teeth were cleaned?: ______________________________
- Previouse Dentist's name?: ______________________________

Address: ______________________ Tel.: (_____)______________________

______________________ Fax: (_____)______________________

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DNT KNOW" ON THE LINE AFTER THE QUESTION.

• Have you made regular visits? :……………………...……....☐Yes ☐No
How often: ______________________________
• Were x-rays taken?:………..☐ Yes ☐No
• Have you lost any teeth or have
any teeth been removed?: …………………………..……...☐Yes ☐No
Why?: ______________________________
• Have any been replaced?: …………………………………☐Yes ☐No
• How have they been replaced?:
a. Fixed bridge:____________ Age:____________
b. Removable bridge: ____________ Age:____________
c. Denture: ____________ Age:____________
d. Implant: ____________ Age:____________

• Are you unhappy with the replacement?:………………....☐Yes ☐No
If yes, explain: ______________________________
• Would you like to know about
permanent replacements?:………………………………...☐Yes ☐ No
• Have you ever had problems or complications
with previous dental treatment?:…………………...…..…☐Yes ☐ No
If yes, explain: ______________________________

• Are you unhappy with the appearance of
your teeth?...☐Yes ☐No

• How do you feel about your teeth in general?:______________
____
____

• Are you sensitive to: ☐Hot? ☐Cold? ☐Sweets? ☐Pressure?

• Do your gums bleed or hurt?:…………………...☐Yes ☐No
When?______________________________
• Do you experience dry mouth?:………………....☐ Yes ☐ No
• Have you had orthodontic work?:……….............☐ Yes ☐ No
• Does your jaw click or pop?.................................☐Yes ☐No
• Do you clench or grind your teeth?.......................☐Yes ☐No
• Have you ever experienced soreness or pain in the
muscles of your face or around your ears?............☐Yes ☐ No
• Do you experience headaches, neckaches or
shoulder aches?..☐Yes ☐No
• Does food get caught in your teeth?:………..…..☐Yes ☐No
• Do you feel your breath is offensive at times?:.....☐Yes ☐No

• Do you brush your teeth?:______________________.
When?:______________________.
• Do you floss your teeth?:______________________.
How often?:______________________.

• Are any of your teeth loose, tipped, shifted
or chipped?:……………………………………...☐Yes ☐No

• Have you had gum surgery?:………..…...………☐Yes ☐ No
What?:______________________
When?:______________________
Where?:______________________

• Have you had any unpleasant dental experiances or is there
anything you stongly dislike about dentistry?:______________
____

• Do you have any questions or concerns?:……………….☐Yes ☐No ____
____

Signature of patient (or parent) ______________________________________ Date __________________

DENTISTRY FOR THE WHOLE FAMILY

Financial Agreement

Payment in full for all charges is required at the time of your visit unless prior arrangements have been made.

Insurance Filing

The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

Assignment of Insurance Benefits

I/We hereby assign directly to Bonnie B. Savoy, D.D.S., dental insurance benefits otherwise payable to me/us. I /We hereby authorize the release of any information relating to any claims. I/We understand I/We are financially responsible for charges not paid by this assignment.

Delinquent Accounts

All delinquent accounts (30days or older) are subject to reasonable service charges/ or legal interest fees.

Collection Proceedings

In the event your account is turned over to a collection agency you will be responsible for payment of any collection cost and or/attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and or/discounts will be reversed and you will be responsible for payment of the regular fee for the services rendered.

Failed Appointments

Failed appointments (less than 24 hours notice) are a significant contributor to rising health costs. Individuals who fail to show for a confirmed appointment may be subject to a cancellation fee based on a percentage of the scheduled procedure.

I authorize contact from this office to CONFIRM MY DENTAL APPOINTMENTS

- Cell phone___________________________
- Email:_______________________________
- Home phone:__________________________

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

_______________________________	_______________________________
Responsible Party Signature	**Witness/Title**