

Patient Information

Today's Date ___/___/___

Patient Name:

First Middle Last

I like to be called: _____

___ Male ___ Female

Birth Date ___/___/___

SS# ___ - ___ - ___

Mailing Address: _____

Apartment/Condo# _____

City State Zip

___ Single ___ Married ___ Child

___ Widowed ___ Divorced

Home#(____) _____ Work#(____) _____

Pager(____) _____ Cell#(____) _____

Email _____

Employer _____

Occupation _____

Person responsible for billing on this account if different from above:

Name _____

Address _____

City _____ ST _____ Zip _____

SS# ___/___/___ Phone _____

Relationship to patient _____

Dental Insurance Information

Primary Dental Insurance

Ins. Co. Phone# _____

Group/Policy# _____

Employee's Name _____

Employee's Birthdate ___/___/___

Employee's SS# ___ - ___ - ___

Employer _____

Employers address _____

Employers phone # _____

Relationship to patient:

___ Parent ___ Spouse

Secondary Dental Insurance

Ins. Co. Phone# _____

Group/Policy# _____

Employee's Name _____

Employee's Birthdate ___/___/___

Employee's SS# ___ - ___ - ___

Employer _____

Employers address _____

Employers phone # _____

Relationship to patient:

___ Parent ___ Spouse

Full Time Student ___ Yes ___ No

(If patient is older than 18)

School Name: _____

Emergency contact

Friend/Relative: _____

Phone # _____

Referred By: _____

**IN SIGNING THIS FORM I
ACKNOWLEDGE THAT EVEN IF I HAVE
INSURANCE, I AM UNLTIMATELY
RESPONSIBLE FOR ANY CHARGES
INCURRED. ANY BALANCE OVER 90
DAYS PAST DUE WILL INCUR FINANCE
AND/OR MONTHLY SERVICE CHARGES.
IF SENT TO COLLECTIONS ALL
COLLECTION FEES WILL BE DUE FROM
THE RESPONSIBLE PARTY.**

Signature: _____

Medical History

PATIENT NAME _____ **BIRTHDATE** _____

Date: _____

Name of Your Physician: _____ Office Telephone _____

Address of Your Physician: _____

1. Are you in good health?.....Yes No Don't know
2. Has there been any change in your health in the last year?.....Yes No Don't know
If yes, explain: _____

3. Have you ever been hospitalized, had a major operation or serious illness?.....Yes No Don't know
If yes, explain: _____

4. Date of your last visit to the doctor: _____ Reason for last visit: _____

5. Are you currently receiving treatment or regular medical care by your doctor?.....Yes No Don't know
If yes, for what conditions: _____

6. Are you taking any of the following medications:

a.	Antibiotics or sulfa drugs.....	Yes	No	Don't know
b.	Anticoagulants (blood thinners).....	Yes	No	Don't know
c.	Cortisone.....	Yes	No	Don't know
d.	Tranquilizers.....	Yes	No	Don't know
e.	Antihistamines.....	Yes	No	Don't know
f.	Aspirin (on a regular basis).....	Yes	No	Don't know
g.	Insulin, tolbutamide (Orinase) or other drugs for diabetes.....	Yes	No	Don't know
h.	Birth control pills or other hormones.....	Yes	No	Don't know
i.	Pain medication such as Advil, Nuprin, Motrin, or Naprosyn.....	Yes	No	Don't know
j.	Synthroid or other thyroid medication.....	Yes	No	Don't know
k.	AZT or other medication for HIV.....	Yes	No	Don't know
l.	Have you ever taken Pamidronate (Aridia) or Zometa.....	Yes	No	Don't know
m.	Other medications please list _____			
n.	Do you take high blood pressure medication? _____ If so, please list medication _____			
o.	Do you need to premedicate for dental treatment? _____ If yes, please list medication _____			

7. Have you ever taken fen-phen (fenfluramine/phentermine combination)?..... Yes No Don't know
If so, have you had a cardiac (heart) exam by your physician?.....Yes No Don't know
8. Have you had any allergic or unusual reactions to any substance (e.g. latex)Yes No Don't know
Have you had any allergic or unusual reactions to any medication.....Yes No Don't know
If yes, specify what substance/medication, and what reactions _____

9. Women: Is there a possibility you are pregnant? _____ Due Date: _____ Are you nursing? _____

PLEASE CHECK ONLY THE CONDITIONS THAT APPLY TO YOU:

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Allergy to anesthetic | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pace maker |
| <input type="checkbox"/> Allergy to medicines/drugs | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pain in jaw joints |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Stomach/ Intestinal ulcers |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Cancer- Chemotherapy | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Jaundice | |
| | <input type="checkbox"/> Kidney problems | |
| | <input type="checkbox"/> Liver disease | |

HABITS AND PERSONAL HISTORY:

1. Do you know or have you ever used recreational drugs? _____ How often? _____
2. Do you smoke? ____ If yes, how many packs a day? _____
3. How many drinks of beer, wine or liquor do you have a day? _____
4. Do you clench or grind your teeth? ____ YES ____ NO
5. Do you have any other dental habits like biting fingernails or chewing ice? _____
6. How often do you get dental check-ups? _____
7. How often do you have your teeth cleaned? _____
8. How do you take care of your teeth and gums? _____
9. Have you ever had any specialized dental treatment (other than routine cleanings and fillings)? _____
10. _____
Have you ever experience prolonged bleeding following dental treatment? _____
11. _____
Have you ever had dental complications following dental treatment? _____
12. _____
Have you had any injury to your teeth, jaws, or face? _____
13. _____
Have you ever or do you currently suffer from Anorexia or Bulimia? ____ YES ____ NO

CURRENT DENTAL CONCERNS:

14. What is your major dental concer? _____
15. Are you unhappy with the appearance of your teeth?..... Yes.....No
16. Do your gums bleed when you brush or eat?..... Yes.....No
17. Does food or dental floss catch between your teeth?..... Yes.....No
18. Are some of your teeth becoming loose?..... Yes.....No
19. Are your teeth sensitive to hot, cold or pressure?..... Yes.....No
20. Do you experience pain or clicking in your jaw joints?..... Yes.....No
21. Are there sore or growths in your mouth?..... Yes.....No
22. Do you have any other dental concerns or problems? _____

Signature of Patient, Parent or Guardian: _____ **Date:** _____

Signature of Doctor: _____ **Date:** _____

Valley Dental, LLC

Financial Responsibility

Dear Patients,

Due to all various insurance plans now in effect, it has become very complicated to become familiar with your plan. We therefore require that all patients provide all necessary information from their insurance company. It is the patient's responsibility to know your coverage and limitations. We will continue, as a courtesy to our patients, to file claims to your insurance company for services rendered. **This does not guarantee payment from your insurance company.** Any claims denied or rejected by your insurance company will become the patient's responsibility.

All various companies and plans have their individual requirements regarding payment portion, co-pays and deductibles. Our office policy requires payment in full at the time of service. We accept cash, check, Visa or Mastercard.

Thank you for your cooperation so that we can better serve you and give you the proper care that you deserve.

I have read and understood the above Financial Policy:

(Signature of patient or responsible party)

(Date)