

# PATIENT INFORMATION

CONFIDENTIAL

NICKNAME \_\_\_\_\_

(PLEASE PRINT)

SS# \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
FIRST MI LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED

PATIENT'S OR PARENT'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
(Circle one)

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE OR PARENT'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PLACE \_\_\_\_\_  
(Circle one)

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

## INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE PAYMENT OF MEDICAL/DENTAL BENEFITS TO GEOFF DEAN, DMD FOR SERVICES RENDERED.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL, DENTAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF BENEFITS TO GEOFF DEAN, DMD

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

# PATIENT MEDICAL HISTORY

PATIENT NAME

PHYSICIAN \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

**9. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?**

- |  |  |   |  |
|--|--|---|--|
| YES NO<br><input type="checkbox"/> <input type="checkbox"/> LOCAL ANESTHETICS<br>(EG. NOVOCAINE) | YES NO<br><input type="checkbox"/> <input type="checkbox"/> BARBITURATES | YES NO<br><input type="checkbox"/> <input type="checkbox"/> ASPIRIN |  |
| <input type="checkbox"/> <input type="checkbox"/> PENICILLIN OR OTHER<br>ANTIBIOTICS             | <input type="checkbox"/> <input type="checkbox"/> SEDATIVES              | <input type="checkbox"/> <input type="checkbox"/> OTHER             |  |
| <input type="checkbox"/> <input type="checkbox"/> SULFA DRUGS                                    | <input type="checkbox"/> <input type="checkbox"/> IODINE                 |   |  |

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW?   | YES                      | NO                       |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? | <input type="checkbox"/> | <input type="checkbox"/> |
| IF YES, PLEASE LIST: _____  |                          |                          |
| 3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?          | <input type="checkbox"/> | <input type="checkbox"/> |
| IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____                                  |                          |                          |

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 4. DO YOU USE TOBACCO?   | YES                      | NO                       |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. DO YOU USE ALCOHOL?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. DO YOU USE COCAINE? <input type="checkbox"/> METH? <input type="checkbox"/> MARIJUANA? <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. DO YOU USE OTHER DRUGS?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. ARE YOU WEARING CONTACT LENSES?   | <input type="checkbox"/> | <input type="checkbox"/> |

**10. WOMEN ONLY:**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? | YES                      | NO                       |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| B) ARE YOU NURSING?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| C) ARE YOU TAKING BIRTH CONTROL PILLS?            | <input type="checkbox"/> | <input type="checkbox"/> |

**11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?**

- |   |  |   |   |
|---|--|---|---|
| YES NO<br><input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE<br><input type="checkbox"/> <input type="checkbox"/> HEART ATTACK<br><input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER<br><input type="checkbox"/> <input type="checkbox"/> SWOLLEN ANKLES<br><input type="checkbox"/> <input type="checkbox"/> FAINTING / SEIZURES<br><input type="checkbox"/> <input type="checkbox"/> ASTHMA<br><input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE<br><input type="checkbox"/> <input type="checkbox"/> EPILEPSY / CONVULSIONS<br><input type="checkbox"/> <input type="checkbox"/> LEUKEMIA<br><input type="checkbox"/> <input type="checkbox"/> DIABETES | YES NO<br><input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASES<br><input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV INFECTION<br><input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEM<br><input type="checkbox"/> <input type="checkbox"/> HEART DISEASE<br><input type="checkbox"/> <input type="checkbox"/> CARDIAC PACEMAKER<br><input type="checkbox"/> <input type="checkbox"/> HEART MURMUR<br><input type="checkbox"/> <input type="checkbox"/> ANGINA<br><input type="checkbox"/> <input type="checkbox"/> FREQUENTLY TIRED<br><input type="checkbox"/> <input type="checkbox"/> ANEMIA<br><input type="checkbox"/> <input type="checkbox"/> EMPHYSEMA | YES NO<br><input type="checkbox"/> <input type="checkbox"/> CANCER<br><input type="checkbox"/> <input type="checkbox"/> ARTHRITIS<br><input type="checkbox"/> <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT<br><input type="checkbox"/> <input type="checkbox"/> HEPATITIS A B OR C<br><input type="checkbox"/> <input type="checkbox"/> JAUNDICE<br><input type="checkbox"/> <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE<br><input type="checkbox"/> <input type="checkbox"/> STOMACH TROUBLES / ULCERS<br><input type="checkbox"/> <input type="checkbox"/> CHEST PAIN<br><input type="checkbox"/> <input type="checkbox"/> EASILY WINDED<br><input type="checkbox"/> <input type="checkbox"/> STROKE | YES NO<br><input type="checkbox"/> <input type="checkbox"/> HAY FEVER / ALLERGIES<br><input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS<br><input type="checkbox"/> <input type="checkbox"/> RADIATION THERAPY<br><input type="checkbox"/> <input type="checkbox"/> GLAUCOMA<br><input type="checkbox"/> <input type="checkbox"/> RECENT WEIGHT LOSS<br><input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE<br><input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE<br><input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS<br><input type="checkbox"/> <input type="checkbox"/> OTHER |
|---|--|---|---|

- |   |                          |                          |   |                          |                          |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
|   | YES                      | NO                       |   | YES                      | NO                       |
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?                       | <input type="checkbox"/> | <input type="checkbox"/> | 12. IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE? _____          | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?               | <input type="checkbox"/> | <input type="checkbox"/> | 13. WOULD YOU LIKE A FREE SMILE CONSULTATION?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?             | <input type="checkbox"/> | <input type="checkbox"/> | 14. DO YOU HAVE FREQUENT HEADACHES?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?                               | <input type="checkbox"/> | <input type="checkbox"/> | 15. DO YOU CLENCH OR GRIND YOUR TEETH?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?                | <input type="checkbox"/> | <input type="checkbox"/> | 16. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?                         | <input type="checkbox"/> | <input type="checkbox"/> | 17. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? |                          |                          | 18. HAVE YOU HAD ANY ORTHODONTIC WORK?  | <input type="checkbox"/> | <input type="checkbox"/> |
| A) CLICKING?  | <input type="checkbox"/> | <input type="checkbox"/> | 19. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| B) PAIN (JOINT, EAR, SIDE OF FACE)?                                     | <input type="checkbox"/> | <input type="checkbox"/> | 20. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? | <input type="checkbox"/> | <input type="checkbox"/> |
| C) DIFFICULTY IN OPENING OR CLOSING?                                    | <input type="checkbox"/> | <input type="checkbox"/> | 21. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| D) DIFFICULTY IN CHEWING?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 8. DO YOU WANT TO KEEP YOUR TEETH?                                      | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 9. DO YOU WANT TO AVOID DENTAL EMERGENCIES?                             | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 10. ARE YOU HAPPY WITH YOUR SMILE?                                      | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 11. DO YOU FEEL YOUR TEETH ARE STAINED OR DARK?                         | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

**Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. In the event that the insurance pays to the patient (PPO or Preferred policies), payment in full is expected at time of treatment. Any charges under \$150.00 will be collected at time of services and patient will be responsible for collecting from the insurance company.**

**A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.**

**If for any reason this account is turned over to a collection agency, I agree to pay all costs for collection, including a reasonable attorney fee.**

**SIGNATURE**

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X

\_\_\_\_\_  
PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
DATE