

PATIENT INFORMATION FORM

Please fill out both sides of this form. By doing so we can provide the best care possible and guide you to a healthy visit. The information you give us will help keep your financial account in order and lessen the changes of billing errors.

Date: _____

Patient's Name _____ Sex: Male _____ Female _____
Last First Middle

Address: _____
Street Address Apt. # City/State/Zip

Email Address: _____ Phone: _____
Home Work Cell

Please contact me at: Home Work Cell Email

Birthdate: ____/____/____ Social Security #: _____ Referred By: _____
Month Day Year

Person Responsible for Payment

Relationship to Patient: Self Spouse Parent Other: _____
Last First Middle

Address: _____
Street Address Apt. # City/State/Zip

Email Address: _____ Phone: _____
Home Work Cell

Birthdate: ____/____/____ Social Security #: _____ Driver's License #: _____
Month Day Year

Occupation: _____ Place of Employment: _____

Patient's Spouses Name

Last First Middle

Spouse's Employer: _____ Occupation: _____ Work Phone: _____

Dental Insurance Information (need copy of cards) Insured's Name (Employee): _____

Insured's Address (if different from above): _____

Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Insurance Co. Name: _____ Group Name: _____ Phone #: _____

Insurance Co. Address: _____ Policy #: _____

Do you have secondary coverage? Yes No If yes, Insured's Name (Employee): _____

Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Insurance Co. Name: _____ Group Name: _____ Phone #: _____

Insurance Co. Address: _____ Policy #: _____

Emergency Information

Name Relationship Telephone #

Financial How will you be paying today? Cash Check Charge Card Care Credit Chase Health Advance

Type of Card: _____ Exp. Date: _____ Card No: _____ Verification #: _____

Authorization: I hereby authorize payment directly to Dr. Bradley J. Daar, DDS of the estimated insurance benefits otherwise payable to me. I understand that I am fully responsible for all costs of dental treatment at time of treatment. In the event that the balance is not paid within 90 days from beginning of treatment, a finance charge will be incurred at a periodic rate of 1.5% per month (annual percentage rate of 18%). I hereby authorize Dr. Bradley J. Daar and his staff to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge. I authorize Dr. Bradley J. Daar, DDS to use my credit card on balances over 30 days.

Signature of Responsible Party Date: ____/____/____
Month Day Year

MEDICAL HISTORY

1. Have you seen a doctor over the past two years for any medical condition? Yes No
 If yes, for what reason? _____ Date you saw the doctor: ____/____/____
Month Year
2. Name of Physician or Primary Health Practitioner: _____ Phone: _____
 Address: _____ City/State/Zip _____
3. Are you taking any over-the-counter or prescribed medications? Yes No
 If yes, please list: _____
4. Any allergies or sensitivity reactions (to substances, drugs, medications)? Yes No
 If yes, please list: _____
5. Are you having dental problems at this time? Yes No
 If yes, please explain: _____
6. Do your gums bleed at any time? Yes No
7. Have you ever had excessive bleeding requiring special treatment? Yes No
 If yes, please explain: _____
8. Do you feel very nervous about having dental treatment? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you ever wake up from sleep short of breath? Do you snore? Yes No
11. Are you a smoker? Yes No
12. Do you use or have you ever used recreational drugs? Yes No
13. Check any of the following which you have had or have at present:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart (surgery, disease, attack) | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Implants (Physical or Dental) |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Delayed Healing | <input type="checkbox"/> Cortisone Medication |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Hepatitis B (Serum) |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A (Infectious) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> H.I.V. Positive |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> A.I.D.S. |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Chemotherapy (cancer, leukemia) | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Pain in Jaw/Joints | <input type="checkbox"/> Drug Addition |

14. Any disease, condition, problem or concern that is not listed? Yes No
 If yes, please explain: _____

15. Women: Are you pregnant? Yes No If yes, what month are you due? _____

16. Women: Are you nursing? Yes No Are you taking birth control pills? Yes No

When was your last dental visit? _____ When was the last time you had complete dental x-rays taken? _____

How do you feel about getting and maintaining a healthy mouth? _____

How do you feel about the appearance of your teeth? _____

If you could change anything about your smile, what would you change? _____

I certify that I have read and understand the questions above. Any question that I had in regard to these questions has been answered to my complete satisfaction. I will not hold my Dentist responsible for any errors or omissions that I may have made in completion of this form. I will advise the dental office staff and the Dentist of any changes in my physical condition, health, and/or changes in my medication.

Date: ____/____/____
Month Day Year

Signature of Parent (or Legal Guardian)

Updates (Date and Initial) _____