# Patient Information

First Name:__________________ Last Name:_______________ MI:____

Patient is: ☐ Policy Holder Preferred Name:________________

☐ Responsible Party

## Patient Information

Address:____________________________________________________________________

City:___________________ State:_______ Zip:___________________

Home Phone:________________ Work:_______________ Cell:_________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced

Birth Date:______________ Age:_______ Social Sec:__________________

Drivers License:______________________ Email:_____________________________

I would like to receive correspondences via e-mail: ☐ yes ☐ no

Employment status: ☐ Full time ☐ Part time ☐ Retired

Student Status: ☐ Full time ☐ Part time

Referred By: ☐ TV ☐ Radio ☐ Patient:_________________

Previous Dentist:_______________________ Last time to a dentist:_________________

Emergency Contact:_________________ Emergency Contact Phone #_______________

## Responsible Party (if someone other than the patient)

First Name:___________________________ Last Name:_____________________ MI:____

Address:______________________________ City/State/Zip:__________________________

Home Phone:___________________ Cell:________________ Work:______________

Birth date:______________ Soc Sec:_________________ Drivers Lic:__________________

## Primary Insurance Information

Policy Holder:___________________________

Relationship to Patient: □ Self □ Spouse □ Child □ Other

Policy Holders Soc. Sec:_____________________ Date of Birth:______________

Policy Holders ID #_________________________ Patients ID#_______________________

Employer:__________________________ Ins. Company:___________________________

## Secondary Insurance Information

Policy Holder:_____________________________

Relationship to Patient: □ Self □ Spouse □ Child □ Other

Policy Holders Soc. Sec:_____________________ Date of Birth:______________

Policy Holders ID #_________________________ Patients ID#_______________________

Employer:__________________________ Ins. Company:___________________________

# Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Healthy problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? □ Yes □ No

If yes, please explain:_____________________________________________

Have you ever been hospitalized or had a major operation? □ Yes □ No

If yes, Please explain:_____________________________________________

Have you ever had a serious head or neck injury? □ Yes □ No

If yes, Please explain:_____________________________________________

Are you taking any medications, pills, or drugs? □ Yes □ No

If yes, Please explain:_____________________________________________

____________________________________________________________________

Do you take, or have you taken, Phen-Fen or Redux? □ Yes □ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? □Yes □ No

Are you on a special Diet? □ Yes □ No

Do you use tobacco? □ Yes □ No

Do you use any controlled Substances? □ Yes □ No

Pregnant/Trying to get pregnant? □ Yes □ No

Taking Oral Contraceptives? □ Yes □ No Nursing? □ Yes □ No

**Are you allergic to any of the following?**

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Other:____________________________________________________

**Do you have or have you had, any of the following?**

| Condition | Response | Condition | Response |
|---|---|---|---|
| AIDS/HIV | □ Yes □ No | Emphysema | □ Yes □ No |
| Alzheimer's Disease | □ Yes □ No | Epilepsy/Seizures | □ Yes □ No |
| Anaphylaxis | □ Yes □ No | Excessive Bleeding | □ Yes □ No |
| Anemia | □ Yes □ No | Excessive Thirst | □ Yes □ No |
| Angina | □ Yes □ No | Fainting Spells/Dizziness | □ Yes □ No |
| Arthritis/Gout | □ Yes □ No | Frequent Cough | □ Yes □ No |
| Artificial Heart Valve | □ Yes □ No | Frequent Diarrhea | □ Yes □ No |
| Artificial Joint | □ Yes □ No | Frequent Headaches | □ Yes □ No |
| Asthma | □ Yes □ No | Genital Herpes | □ Yes □ No |
| Blood Disease | □ Yes □ No | Glaucoma | □ Yes □ No |
| Blood Transfusion | □ Yes □ No | Hay Fever | □ Yes □ No |
| Breathing Problem | □ Yes □ No | Heart Trouble/Disease | □ Yes □ No |
| Bruise Easily | □ Yes □ No | Hemophilia | □ Yes □ No |
| Cancer | □ Yes □ No | Hepatitis A | □ Yes □ No |
| Chemotherapy | □ Yes □ No | Hepatitis B or C | □ Yes □ No |
| Chest Pains | □ Yes □ No | Herpes | □ Yes □ No |
| Cold Sores/Fever Blisters | □ Yes □ No | High Blood Pressure | □ Yes □ No |
| Congenital Heart Disease | □ Yes □ No | Hives or Rash | □ Yes □ No |
| Convulsions | □ Yes □ No | Hypoglycemia | □ Yes □ No |
| Cortisone Medicine | □ Yes □ No | Irregular Heartbeat | □ Yes □ No |
| Diabetes | □ Yes □ No | Kidney Problems | □ Yes □ No |
| Drug Addiction | □ Yes □ No | Leukemia | □ Yes □ No |

| | | | |
|---|---|---|---|
| Low Blood Pressure | □ Yes □ No | Sickle Cell Disease | □ Yes □ No |
| Lung Disease | □ Yes □ No | Sinus Trouble | □ Yes □ No |
| Mitral Valve Prolapse | □ Yes □ No | Spina Bifida | □ Yes □ No |
| Osteoporosis | □ Yes □ No | Stomach/Intestinal Disease | □ Yes □ No |
| Pain in Jaw Joints | □ Yes □ No | Stroke | □ Yes □ No |
| Parathyroid Disease | □ Yes □ No | Swelling of Limbs | □ Yes □ No |
| Psychiatric Care | □ Yes □ No | Thyroid Disease | □ Yes □ No |
| Radiation Treatment | □ Yes □ No | Tonsillitis | □ Yes □ No |
| Recent Weight Loss | □ Yes □ No | Tuberculosis | □ Yes □ No |
| Renal Dialysis | □ Yes □ No | Tumors or Growths | □ Yes □ No |
| Rheumatic Fever | □ Yes □ No | Ulcers | □ Yes □ No |
| Rheumatism | □ Yes □ No | Venereal Disease | □ Yes □ No |
| Scarlet Fever | □ Yes □ No | Yellow Jaundice | □ Yes □ No |
| Shingles | □ Yes □ No | | |

Have you ever had any serious Illness not listed above? □ Yes □ No

If yes, please explain:_______________________________________________

**Comments**:_______________________________________________

_______________________________________________

_______________________________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, or Responsible Party:______________________ Date:____________

# Sisters Dental Financial Options

Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology.

**Method of Payment:**

* Cash, Check, or Credit Card (Visa, Mastercard)
* Dental Insurance as described below
* Care Credit (subject to credit approval with Care Credit)
* **Please note we do not have an in house financing plan and will not take payments on accounts.**

**Dental Insurance:**

* We are pleased you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company. We will need you to bring us a copy of your benefit booklet if you would like help interpreting your benefits.
* As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the insurance payment authorization. However if payments by your insurance are not received in a timely manner or if your insurance company or benefits change without giving us notification the payment will be your responsibility and any amount received by your insurance at a later time will be refunded to you.
* Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover. It is your responsibility as a patient to know your benefits, as it is a contract between you, your employer and your insurance company.

**Related Information:**

Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month or 18% annually. These additional fees will be applied to the unpaid balance at the end of the month.
In the event that the account is not paid and we refer the account to collections, you will be responsible for all fees incurred for collection of your bill (i.e. Attorney fees, Court costs, and Collection Agency fees).
Your appointment time has been reserved exclusively for you. Any change in your appointment requires a **24** hours notice to avoid a charge of $50.00
I have read and understand the above information. I understand I am responsible regardless of my insurance for any charges incurred from services rendered.

Name___________________________________________________________

_________________________________________________________________ Date__________________
Signature of patient or responsible party

# Sisters Dental
## Acknowledgement of Receipt of Privacy Practices

The Notice of Privacy Practices describes how health information about you may be used and disclosed and how you can get access to this information. Please review the Notice carefully.

By signing below I acknowledge that:

- A copy of the Notice of Privacy Practices has been provided for me to read and a copy is available upon request at now or at any time in the future.
- I am either the patient or the patient's responsible party.

______________________________________________________________

Signature of patient or responsible party Date