HEALTH HISTORY AND INSURANCE INFORMATION

Today's date _____

Patient Name _____ Birthday _____ M_____F_____
Last First Initial

Address _____ City _____ Zip Code _____

Home phone # _____ Work phone # _____ Mobil phone # _____

Email address: _____

Father (minor patient only)_____ Birthday _____ SSN# _____

Mother (minor patient only)_____ Birthday _____ SSN# _____

Emergency contact person _____ Phone # _____

DENTAL HISTORY

Reason for today's visit _____

Former dentist _____ Phone _____

Date of last dental care _____ Date of last dental X-rays _____

Check (**X**) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment or surgery
- ☐ Sensitivity to: hot/cold/sweets/biting
- ☐ Sores or growths in your mouth
- ☐ Food collection between teeth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last physical exam _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Female) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control Pills? ☐ Yes ☐ No

Check (**X**) if you have or have had any of the following:

- ☐ ADHD
- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Chemical Dependency
  Describe _____
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Problems
  Describe _____
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Peace maker
- ☐ **Pre-Med** (dental visit)
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Swelling of Feet/Ankles
- ☐ Syndromes
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

☐ Other _____

☐ **None of the above**

OVER

MEDICATIONS

List medications you are currently taking _____

_____

Pharmacy Name _____ Phone _____

ALLERGIES

☐ Codeine ☐ Latex ☐ Metal
☐ Penicillin ☐ Sulfa ☐ **None of the above**

☐ Others _____

INSURANCE INFORMATION

Primary insurer/subscriber name _____

Carrier name and address _____

Subscriber's SS or ID number _____ Date of Birth _____ Group number _____

Relationship to patient ☐ Self ☐ Father ☐ Mother ☐ Spouse ☐ Other

Secondary insurer/subscriber name _____

Carrier name and address _____

Subscriber's SS or ID number _____ Date of Birth _____ Group number _____

Relationship to patient ☐ Self ☐ Father ☐ Mother ☐ Spouse ☐ Other

ASSIGNMENT AND RELEASE AGREEMENT

I, the undersigned, have read/received the acknowledgment of Notice of Privacy Practices. I authorized the use of this signature on all my insurance submissions (manual or electronic).

X_____

FINANCIAL AGREEMENT

I (parents/guardians for minor patients) agree and accept full financial responsibility for all charges not covered by my insurance. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. Furthermore, I also acknowledge that V Dental Center has reserve the rights to apply the finance charges, late payment charges and/or impose collection fees on any outstanding and/or Delinquent account.

X_____

CANCELLED-FAILED POLICY AGREEMENT

I have read and understand the V Dental Center's Cancelled-Failed Policy. I acknowledge that V Dental Center has reserve the right to charge for appointments cancelled or broken without a 48 hours advanced notice (2 weeks for hospital appointments). I accept full financial responsibility for all charges associated with failed appointments (up to $200.00 for missed/failed appointment).

X_____

MINOR/CHILD CONSENT AGREEMENT

I, being the parent or guardian of the patient, do hereby request and authorize the dental staff to perform necessary dental services for My child, including but not limited to, X-rays, administration of anesthetics, nitrous oxide and/or pedo wrap, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

X_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____Signature_____

Signature of insured/Parents/Guardian/Provider