WELCOME

PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARD

≈≈ ABOUT YOU≈≈

Today's Date: ______________ SS#: ________________________________

Name: ____
Last First Middle Name

I prefer to be called: __________________________ Birthdate: _____/_____/_____ Age: _____ ☐Male ☐Female

Home Address: ____
City State Zip Code

Home #: (_____) ________________ Cell #: (_____) ____________________ Work #: (_____) ___________________

Email Address: ____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Partner

Employer: ____ Address: ____

Whom may we thank for referring you? ____

Previous/Present Dentist: _________________________________ Phone #: ________________ Last Visit Date: __________

≈≈INSURANCE INFORMATION≈≈

PERSON RESPONSIBLE FOR ACCOUNT: ____

Relationship:_______________________ Birthdate: _______/_______/_______ SS #: __________________________

Employer: ____

Billing Address: ____

Home #: (______) ___________________ Work #: (_______) ______________________

PRIMARY INSURANCE Dental Coverage ☐YES ☐NO

Insurance Co. Name: ____

Subscriber's Name: ____Birthdate_______________ SS#_________________

SECONDARY INSURANCE Dental Coverage ☐YES ☐NO

Insurance Co. Name: ____

Subscriber's Name: ____Birthdate_______________ SS#_________________

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PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

CANCELLATION POLICY

I have been informed of St. Charles Family Dentistry Ltd's cancellation policy. If I do not provide at least 24 hours notice or fail to attend appointment I agree to pay a fee of $100.00 if scheduled with the Doctor and a fee of $75.00 if scheduled with the hygienist. (Initial) _________

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____

SIGNATURE DATE

≈≈ DENTAL HISTORY≈≈

WHY HAVE YOU COME TO THE DENTIST TODAY? ____________________

Are you currently in pain? ☐YES ☐NO Do you require antibiotics before dental work (Pre-Med)? ☐YES ☐NO

≈≈ MEDICAL HISTORY≈≈

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT: ____________________

Physician's Name: ____________________ Phone: ____________

Are you currently under the care of a physician? Why?____________________

Date of Last visit: __________ Your current physical health is ☐Good ☐Fair ☐Poor

Do you have a history of smoking or using tobacco products? ☐YES ☐NO

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ☐YES ☐NO

Have you had a heart valve replacement or total joint replacement? ☐YES ☐NO

Please list any prescription, over-the-counter or herbal supplement drugs you are taking?

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS

Y N	Anormal Bleeding/Hemophilia	Y N	Glaucoma	Y N	Seizures
Y N	AIDS	Y N	Head Injuries	Y N	Shingles
Y N	Alcohol/Drug Abuse	Y N	Heart Disease	Y N	Sinus Problems
Y N	Anemia	Y N	Heart Attack	Y N	Sleeping problems
Y N	Arthritis	Y N	Heart Murmur	Y N	Stomach problems
Y N	Artificial Bone/Joints/Valves	Y N	Hemophilia/Blood clot issues	Y N	Stroke
Y N	Blood Transfusion/Blood Disease	Y N	Hepatitis	Y N	Thyroid Problems
Y N	Cancer/Chemotherapy	Y N	High/Low Blood Pressure	Y N	Tuberculosis
Y N	Colitis	Y N	HIV	Y N	Tumors/Growths
Y N	Congenital Heart Defect	Y N	Jaundice	Y N	Ulcers
Y N	Cosmetic Surgery	Y N	Kidney Disease/Problems	Y N	Venereal Disease/STD's
Y N	Cholesterol	Y N	Liver Disease		
Y N	Diabetes (Type 1 or Type 2)	Y N	Mental Disorders/Psychiatric Health Concerns		
Y N	Difficulty breathing	Y N	Metal Rods or Pins		
Y N	Dizziness	Y N	Mitral Valve		Other Conditions:
Y N	Emphysema	Y N	Nervous Disorders		
Y N	Epilepsy	Y N	Pacemaker		
Y N	Excessive Bleeding	Y N	Radiation Treatment		
Y N	Fainting	Y N	Respiratory Problems		
Y N	Fever blisters/Cold sores	Y N	Rheumatic Fever/Scarlett fever		
Y N	Frequent headaches	Y N	Rheumatism/RA		

Please list any serious medical conditions that you have ever had: ____________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry/Metal	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs/materials that you are allergic to: ____________________

FOR WOMEN: Are you using birth control? ☐YES ☐NO Pregnant? ☐YES ☐NO Due:________ Nursing? ☐YES ☐NO

Anything you would like to discuss with the dentist in private? ☐YES ☐NO ____________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____

SIGNATURE DATE

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FOR OFFICE USE ONLY

Reviewed medical/dental information with patient: ______________ Date:________ Comments: