Gerome and Patrice Dental, LLC

Chart # _____ **Patient Information** **Date:** _____

Patient Legal Name: Last_____First_____MI_____

Prefer to be called: _____ Sex: M or F Marital Status: Married Single Divorced Widowed

SS #:_____ DOB: _____ Email: _____

Phone (home):_____ (work): _____ (cell):_____

Preferred method of communication: cell phone home phone work phone email text message

Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Information

Person responsible for this account: _____

Relationship to Patient: _____ DOB: _____ SS#:_____

Address: _____

City: _____ State: _____Zip Code: _____

Responsible Party Employer: _____

Insurance Company: _____ ID#:_____ Group#_____

Insurance Address: _____ Ph#: _____

Referral Information

Whom may we thank for referring you to our practice? _____

Emergency Contact

Name: _____Ph#: _____

Cancellation Policy

It is our goal to provide excellent patient care in a relaxed and caring setting. Appointment times are exclusively reserved for each patient. For this reason we require 24 hours advance notice for all schedule changes or cancellations. We reserve the right to apply a broken appointment fee for changes made with less than 24 hours' notice.

Authorization Policy

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in health. I authorize the use of this signature as "signature on file" for all benefit submissions. I authorize my insurance company to pay Gerome and Patrice Dental. I authorize the dentist to release any information necessary to secure payment of benefits. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents. I consent to the use and disclosure of my protected health information to carry out healthcare operations, treatment, and payment activities. I have received a copy of the office Notice of HIPAA Privacy Practices.

Signature of Patient or Legal Guardian: _____ Date: _____

Health Information

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

Date of last dental cleaning: _____What is the nature of today's visit? _____

Does your physician require you to take medication before dental care? Yes or No

If yes, who is the physician: _____ Medication and dosage: _____

Are you under a physician's care now? Yes or No Physician name: _____

If yes, please explain: _____

Have you ever been diagnosed with sleep apnea? Yes or No Have you been told that you snore? Yes or No

Serious head or neck injury? Yes or No If yes, please explain: _____

Any complications following dental treatment? Yes or No If yes, please explain: _____

Is there something you would like to improve with your smile? Yes or No Have you ever had Botox? Yes or No

Please list any medications, vitamins, or supplements (including CBD) you are currently taking: _____

_____

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

Do you use any tobacco products (Cigarettes, Cigars, chew, dip, or e-cigarettes)? _____

Are you currently pregnant or nursing? Yes or No

Circle any allergies to the following: Aspirin penicillin codeine acrylic metal latex sulfa drugs local anesthetics

Other allergies: _____

If you have, or had, any of the following please check the box to the left of each item.

□ AIDS/HIV positive	□ Colitis/GI issues	□ Heart pacemaker	□ Rheumatism
□ Alzheimer's or Dementia	□ Congenital heart disorder	□ Heart trouble/disease	□ Radiation Treatments
□ Anaphylaxis	□ Cortisone medicine	□ Hemophilia	□ Recent weight loss
□ Anemia	□ Convulsions	□ Hepatitis A	□ Renal dialysis
□ Asthma	□ Diabetes	□ Hepatitis B or C	□ Rheumatic fever
□ Angina/chest pain	□ Drug addiction	□ Herpes	□ Stomach/Intestinal issue
□ Arthritis/gout	□ Emphysema	□ High blood pressure	□ Swelling of limbs
□ Artificial Heart Valve	□ Epilepsy or seizures	□ High cholesterol	□ Shingles
□ Artificial joint	□ Excessive bleeding	□ Hives or rash	□ Sickle cell disease
□ Anxiety/Depression	□ Excessive thirst	□ Irregular heartbeat	□ Sinus trouble
□ Blood Disease	□ Fainting spells/dizziness	□ Kidney problems	□ Sleep Apnea
□ Bruise Easily	□ Frequent cough	□ Leukemia	□ Stroke
□ Botox Treatment	□ Frequent diarrhea	□ Liver disease	□ Tumors/Growths
□ Breathing Problems	□ Frequent headaches	□ Low blood pressure	□ Tuberculosis
□ Chest Pain	□ Glaucoma	□ Lung disease	□ Thyroid disease
□ Cancer or Tumors	□ GERD/acid reflux	□ Osteoporosis	□ Tonsillitis
□ Chemotherapy	□ Heart attack/failure	□ Pain in jaw joints	□ Ulcers
□ Cold sores/fever blisters	□ Heart murmur	□ Parathyroid Disease	□

Have you ever had any serious illness not listed above? If yes please list: _____

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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian: _____ Date: _____