Patient Information

Legal Name_____

Preferred Name_____

Title: **Mr Ms Mrs Sra Dr Other:**_____

Suffix: **Jr Sr II III MD PhD DDS Other:**_____

Sex: **Female** **Male**

Status: **Adult** **Dependent**

Address _____

City, St, Zip _____

Date of Birth _____

SSN _____

Email _____

Employer _____

Work Phone _____

Cell Phone _____

Home Phone _____

Preferred Daytime Contact Method:

Cell Phone **Work** **Home**

Preferred Appointment Confirmation Method:

Email Texting Home# Work# Cell# PostCard

(Circle all that are acceptable)

Person Financially Responsible For This Patient

(Only if information is different than info above)

Name _____

Address _____

Address _____

City,St Zip _____

Phone _____

Primary Insurance

Subscriber Name _____

Subscriber ID# _____

Address _____

Address _____

City, ST Zip _____

Birthdate _____

Employer _____

Insurance Co. _____

Group Name _____

Group Number _____

Relationship: **Self** **Spouse** **Dependent**

Secondary Insurance

Subscriber Name _____

Subscriber ID# _____

Address _____

Address _____

City, ST Zip _____

Birthdate _____

Employer _____

Insurance Co. _____

Group Name _____

Group Number _____

Relationship: **Self** **Spouse** **Dependent**

Treatment Consent (Required)

I give authorization to doctor and staff to:

- Perform any necessary dental services that may be needed during diagnosis and treatment.
- Release information, records and radiographs to consulting professionals as needed.

_____

Signature of patient or authorized responsible party Relationship Date

Insurance Agreement (Required if you want us to file your dental insurance)

- I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions.
- I understand that an estimated portion based on expected coverage is due at the time of service.
- I understand that my portion may be more if my insurance company does no t pay the anticipated amount.
- I authorize the release of any and all information necessary to process my dental claim.
- I authorize my insurance company to pay benefits directly to Dr. Margarit for services rendered and that I am responsible for all charges not covered by insurance benefits.

_____

Signature of patient or authorized responsible party Relationship Date

HIPAA Acknowledgment (required for everyone)

- I have been given a copy of this office's Notice of Privacy Practices (HIPAA) and have been advised that a copy is available on request.
- I consent to the use of my health information in a manner consistent with this notice.

_____

Signature of patient or authorized responsible party Relationship Date

Permission To Share Protected Health Information (If you want a spouse, significant other or family member to have access to your Protected Health Information (PHI) and/or assist you in making treatment decisions.)

I give authorization to the doctor and staff to share my protected health information with the following people:

- Name:_____ Relationship:_____ Initials:_____
- Name:_____ Relationship:_____ Initials:_____
- Name:_____ Relationship:_____ Initials:_____

Dental Conditions:

- ❑ Are you apprehensive about dental treatment?
- ❑ Have you had bad dental experiences in the past?
- ❑ Do you gag easily?
- ❑ Does food get stuck between your teeth?
- ❑ Do you avoid chewing on one side?
- ❑ Do your gums bleed easily?
- ❑ Do you get apthous ulcers (canker sores)?
- ❑ Do you get herpes sores (cold sores)?
- ❑ Do you have any non-healing oral sores?
- ❑ Are your teeth highly sensitive to hot or cold?
- ❑ Are your teeth sensitive to sweets?
- ❑ Does your jaw hurt when opening, closing or chewing?
- ❑ Do you clench and grind your teeth while sleeping?

Medical Conditions: (Past or present)

Congenital Heart Conditions
Angina
Heart 'Attack'
Bypass Surgery
Artificial Heart Valve
Pacemaker
Heart stents
High Blood Pressure
Low Blood Pressure
Stroke
Cancer
Chemotherapy
Osteoporosis
Liver Disease
Hepatitis A B C D
Kidney Disease
Epilepsy
Seizures
Thyroid Disease
Lung Disease
Bleeding Disorders
Bruise Easily
Tuberculosis
Leukemia
STDs
HIV/AIDS
Artificial Joint(s)
Pins, Plates, Screws, Rods
Drug Addiction
Alcohol Addiction
'Recreational' Drug Use
Other _____

Allergies:

Antibiotics _____
Latex
Sulfa
Sulfites / Bisulfites
Metals
Other _____

Bad Reactions:

Antibiotics
Narcotics
Dental Shots
Nitrous Oxide
Other

Women:

Pregnant
Nursing
Birth Control Pills
Antibiotics cause yeast infections

Medications:

Blood Thinner _____
Heart Medicine _____
Blood Pressure _____
Diabetes _____
Steroids _____
Osteoporosis _____
Antidepressants _____
Others
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Physicians: _____

_____

I certify that the above information is complete and accurate.

_____

(Sign and Date)

Date	Tooth	XRay	Treatment Notes Name:	Initials