



**PETER H. PRUDEN, D.D.S.\*, P.C.**

**\*Diplomate of the American Board of Oral and Maxillofacial Surgery**

**\*Fellow of the American Dental Society of Anesthesiology**

**Patient Information**

Purpose of Visit: \_\_\_\_\_ Date: \_\_\_\_-\_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_ Referring Dentist: \_\_\_\_\_

Patient Name (Last, First, M.I.) \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: M F Martial Status: M S D W

Student Status: \_\_\_\_\_ Full Time: Yes NO Part Time: Yes NO

Name of School: \_\_\_\_\_

Medical Physician: \_\_\_\_\_

**In Case Of Emergency**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**Responsible Party**

Method of Payment: Cash \_\_\_ Check \_\_\_ Credit \_\_\_ Care Credit \_\_\_

Name (parent/guardian): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Current Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

Patients Name: \_\_\_\_\_

High/Low Blood Pressure	Y	N	Chest Pain	Y	N
Heart Murmur or Rheumatic Fever, MVP-Mitral Valve Prolapse	Y	N	Ankles Swollen	Y	N
Heart Disease	Y	N	Glaucoma	Y	N
Diabetes	Y	N	Thyroid Condition	Y	N
Bleeding Tendencies	Y	N	Seizure Disorder	Y	N
Allergies	Y	N	Blood Disease	Y	N
Asthma	Y	N	Cortisone Therapy	Y	N
G.I. Neurological, Kidney, Liver, or Lung Disease	Y	N	Hepatitis A B or C	Y	N
Under Medical Care	Y	N	HIV/AIDS	Y	N
Pregnant	Y	N	Intravenous Drug User/ Blood Transfusion before 1992	Y	N
Osteoporosis	Y	N	Reactions to Local Anesthesia	Y	N
Bone Cancer	Y	N	Reactions to Codeine	Y	N
Any other cancer	Y	N	Reactions to Penicillin	Y	N
Chemo Therapy or Fosomax, Boniva, or Actonel.	Y	N	Reactions to Other Drugs	Y	N
Arrhythmia, Premature Ventricular Contractions, Atrial Fibrillation	Y	N	Reactions to General Anesthesia	Y	N

**Please list all Medications:**

**If NONE check here:** \_\_\_\_\_

**Please list all Allergies:**

**If NONE check here:** \_\_\_\_\_

Have you ever had previous anesthesia/surgery?

Why?

Have you ever been hospitalized?

If yes for what and when?

Do you have any tattoos or body piercings?

If yes how many:

Do you smoke?

If yes how much per day:

Have you ever taken bisphosphonates Fosomax, Actonel, or Boniva?

If yes please list dates started and stopped:

Have you ever received intravenous bisphosphonates such as Zometa (Zoledranate) or Pamidronate (Aredia)?

If yes please list dates started and stopped:

Are you presently under the care of a physician?

Name:

Phone Number:

When did you last eat or drink?

**Women Only:** Are you pregnant? \_\_\_\_\_ nursing? \_\_\_\_\_ taking birth control? \_\_\_\_\_

## INSURANCE INFORMATION

### **Primary Dental Insurance:**

Primary Dental Ins. Carrier \_\_\_\_\_

Mailing Address (on back of card) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Current employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Work Phone # \_\_\_\_\_

### **Secondary Dental Insurance:**

Secondary Dental Ins. Carrier \_\_\_\_\_

Mailing Address (on back of card) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Current employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Work Phone # \_\_\_\_\_

### **Primary Medical Insurance:**

Primary Medical Ins. Carrier \_\_\_\_\_

Mailing Address (on back of card) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Current employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Work Phone # \_\_\_\_\_

### **Secondary Medical Insurance:**

Secondary Medical Ins. Carrier \_\_\_\_\_

Mailing Address (on back of card) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Current employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Work Phone # \_\_\_\_\_

**Release of Information Statement**

I certify that the information given by me on this form is correct. All fees given by insurance company representatives and/or Dr. Pruden's staff are Estimates and not GUARANTEED PAYMENT/ PRICING from insurance companies. I hereby assign benefits to Dr. Pruden and understand that I/legal guardian am responsible for full payment of services rendered and/or deductibles and co-payments or remaining balance after insurance companies have paid Dr. Pruden.

▶ X \_\_\_\_\_ Date: \_\_\_\_\_

**Medicare Patients:** Almost all dental procedures are not covered by Medicare. I understand that I am responsible for insurance deductibles on all services, and 20% co-insurance on ancillary services which are covered.

▶ X \_\_\_\_\_ Date: \_\_\_\_\_

I am allowing the office of Peter H. Pruden DDS PC and Associates to contact me via email:

▶ X \_\_\_\_\_ Date: \_\_\_\_\_

**Collection Fee**

Should there be need to turn over your account to our collection agency, your account will be charged additional reasonable fees including a late fee as well as a collection fee.

▶ X \_\_\_\_\_ Date: \_\_\_\_\_

**HIPPA Acknowledgement of Receipt of Privacy Practices**

I, \_\_\_\_\_, have received a copy of this office's Privacy Practices.

\_\_\_\_\_  
Please Print Name

▶ \_\_\_\_\_  
Signature Date

**Acknowledgement of Insurance Responsibilities**

I, \_\_\_\_\_, have been informed that I am responsible for all fees if I do not have insurance in which Dr. Peter H. Pruden DDS is a participating provider. If I have insurance in which Dr. Peter H. Pruden DDS is a participating provider, I am responsible for all fees my insurance provider does not pay.

▶ \_\_\_\_\_  
Signature Date