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**

***Fellow of the American College of Dentists**

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 _____________________________ ☐ Self

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: _______________________

Pharmacy: ____________________________ **Phone:**_______________________

Town: __________________________ **Road:** ____________________

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

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
Have you travelled to Liberia, Sierra Leone Or Guinea in last 21 days? If yes, date entered USA	Y	N	Are you feeling feverish?	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 your 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. ______________________________**ID#**__________________
Mailing Address (on back of card)_______________________**Group#**:____________
City____________________ State _________ Zip code_____________
Insured's Name____________________________ Date of Birth________________
Social Security #___________________ Relationship to Patient______________
Insured's Address____
City_______________ State_________ Zip code___________ Phone#_____________
Current employer_________________________ Work # __________________
Address____
City___________________ State______ Zip code__________

Secondary Dental Insurance:

Secondary Dental Ins. -____________________________**ID#**__________________
Mailing Address (on back of card)_______________________**Group#**:_____________
City______________________ State________ Zip code____________
Insured's Name____________________________ Date of Birth________________
Social Security #___________________ Relationship to Patient______________
Insured's Address____
City_______________ State_________ Zip Code___________ Phone#______________
Current employer_______________________ Work Phone # __________________
Address____
City___________________ State______ Zip code__________

Primary Medical Insurance: ***(If applicable)***

Primary Medical Ins. -______________________________**ID#**__________________
Mailing Address (on back of card) ____
City______________________ State________ Zip code____________
Group #___________________________________
Insured's Name____________________________ Date of Birth________________
Social Security #___________________ Relationship to Patient______________
Insured's Address____
City_______________ State_________ Zip Code__________ Phone# _______________
Current employer_______________________ Work #______________________
Address____
City___________________ State______ Zip code__________

Secondary Medical Insurance:

Secondary Medical Ins. ______________________________**ID#**___________________
Mailing Address (on back of card) ____
City______________________ State________ Zip code____________
Group #______________________________________
Insured's Name____________________________ Date of Birth________________
Social Security #___________________ Relationship to Patient______________
Insured's Address____
City_______________ State_________ Zip Code__________
Phone#_______________Current employer_________________________________
Work#___________________Address_____________________________________
City______________________________ State______ Zip code__________