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Patient Information Form

Today's Date _____

Patient Name: First _____ MI ___ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-Mail Address _____

By providing your e-mail address, you agree to receive (*check one or both*) ❑ Appointment Reminders ❑ Practice Newsletter

What is your preferred method of contact? ❑ Home Phone ❑ Work Phone ❑ Mobile Phone ❑ E-Mail

Social Security Number _____ Date of Birth _____

Driver's License # _____ Issuing State _____

Patient Employed By _____ Occupation _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient: _____ Home Phone _____ Mobile Phone _____

Is the Patient a minor? ❑ Yes ❑ No Full-time Student? ❑ Yes ❑ No Name of School _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ Relationship to Patient ❑ Self ❑ Spouse ❑ Parent ❑ Other _____

If patient is a minor, primary residence is with ❑ Both parents ❑ Mom ❑ Dad ❑ Step Parent ❑ Shared Custody ❑ Guardian

Address *(if different from above)* Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer *(if different from above)* _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan: Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient's Relationship to Insured _____

Secondary Dental Plan: Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient's Relationship to Insured _____

Whom may we thank for referring you?

❑ One of our valued patients *(name of patient)* _____

❑ Advertisement _____ ❑ Local Dental Society _____

❑ Our website ❑ Other _____

Please list other members of your immediate family who are patients in our practice _____

_____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: cash, check, Visa, MasterCard, AMEX, Discover Card and Care Credit.

Please note: If you elect to apply for third-party financing administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit is a contract between you and your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

The patient understands that he or she is financially responsible for the entire balance, regardless of insurance coverage.

Fees quoted in this estimate are valid for 3 months for treatment completed within that time.

A service charge of 1.5% on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements have been made.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 24-hour notice, a fee of $45.00 or a deposit to reserve the appointment time again may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen (15) minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $45.00 or a deposit to reserve the appointment time again may be required. If a patient does not show on a confirmed appointment, a fee of $90.00 or a deposit to reserve the appointment time again may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consent to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. ❑ Yes ❑ No _____ (initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

Signature _____ **Date** _____

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ **Date of Birth** _____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. **Yes / No** **Is your general health good?**
   If NO, explain _____
2. **Yes / No** **Has there been a change in your health within the last year?**
   If YES, explain _____
3. **Yes / No** **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain _____
4. **Yes / No** **Are you being treated by a physician now?**
   If YES, explain _____
   Date of last medical exam? _____ **Reason for exam** _____
5. **Yes / No** **Have you had problems with prior dental treatment?**
   If YES, explain _____
   Date of last dental exam _____ **Name of last treating dentist** _____
6. **Yes / No** **Are you in pain now?**
   If YES, explain _____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
				Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others _____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Cortico - Steroids
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all medications you are currently taking _____

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?** _____
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain _____

Yes / No **Have you ever been pre-medicated for dental treatment?**
If YES, why _____

Yes / No **Have you ever taken Fen-Phen?**
If YES, when _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

Dr. Edward Montalbo, DMD

Smile Evaluation:

This is a simple questionnaire to help you obtain the smile you've always wanted. Hold a full face mirror 12-14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully. Answer the following questions.

1. Do you like the appearance of your teeth and smile? ____ Yes ____ No
If not, explain_____
_____

2. Are your teeth all in alignment (straight)? ____ Yes ____ No
If not, explain_____
_____

3. Do you have spaces that you don't like? ____ Yes ____ No
If yes, explain_____
_____

4. Do you like the color of your teeth? ____ Yes ____ No
If not, explain_____
_____

5. Do you like the shape of your teeth? ____ Yes ____ No
If not, explain_____
_____

6. Are your teeth ____ Chipped ____ Protruding ____ Hidden?

7. Do you like the way your teeth come together? ____ Yes ____ No
If not, explain_____
_____

8 Are there old fillings or dental work that you don't like looking at? ____ Yes ____ No
If not, explain_____
_____

9. What would you like to change most in the appearance of your smile?
_____
_____

10. How would you like your smile to look?
_____
_____