Elmwood Dental Center – Patient Information Form

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PHONE: (504) 733 -1135

Welcome! Please print this form, fill it out, and bring it with you when you arrive for your scheduled appointment. (Click on the Print icon, or select Print from the File Menu.)

(1) ABOUT YOU

Today's Date _____

Full Name:_____
(Indicate whether Mr., Ms., Mrs., Dr. And please include middle initial)

I prefer to be called:_____

Male___ Female___ Age_____ SS#:_____

Date of Birth_____ I am: Single____ Married____ Divorced____

Home Address (include Apt or Condo #, State And Zip Code):

_____

_____

Day Phone Number:_____Cell/Pager:_____

Night Phone Number:_____ Ext:_____ DL#_____

Your Email Address:_____

Employer:_____

How long employed there?_____ Occupation:_____

How did you find out about us?_____

Who may we THANK for referring you?_____

Other family members seen by us:_____

Nearest relative not living with you:_____ HM#_____

Nearest friend not living with you:_____ HM#_____

Person Responsible For Account:_____

WK#_____ Ext_____ HM#_____

Billing Address_____

_____

Relationship_____ SS#_____

Employer_____ DL#_____

How Paying Today? (circle one): Cash Check Credit Card

(2) SPOUSE INFORMATION

Their Name:_____

Employer:_____ WK#:_____ Ext:_____

SS#:_____ Birth Date_____

Driver's License #:_____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name_____ Relation_____

WK#_____ HM#_____

(3) DENTAL INSURANCE

Primary Dental Insurance

Ins. Co. Name_____ Ins. Co. Phone_____

Ins. Co. Address_____
Group# (Plan, Local or Policy#):_____
Insured's Name:_____ Relation:_____
Insured's Birth Date:_____
Insured's SS#:_____ Insured's Employer:_____

I Understand that Elmwood Dental Center strictly adheres to a "NO BILLING POLICY". I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance not paid within 60 days after treatment begins. In the event of default I (We) promise to pay interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I understand that 48 hours cancellation notice of any scheduled appointments is required. This office also has the option to do a credit report and verify information found therein. Insurance patients are expected to pay their estimated portion that their insurance company will not pay for. I understand and agree to follow these policies.

Please sign:

_____
(Signature required to begin treatment)

I will pay today by (circle one): Cash Check Credit Card

Section (4) MEDICAL HISTORY

1. Y N Are you taking any medications?

2. Y N Are you allergic to any medications or substances? (Penicillin, antibiotics, anesthetics, or other medications, latex, or metals)

3. Women:
   Y N Are you pregnant?
   Y N Do you use birth control medication?

4. Do you have or have you had any of the following?

Y N major surgery
Y N heart trouble
Y N pacemaker
Y N artificial heart valve
Y N leaky heart valve
Y N rheumatic fever
Y N heart murmur
Y N high/low blood pressure
Y N radiation or chemotherapy
Y N mitro valve prolapse
Y N serious illness
Y N arthritis
Y N immunosuppression
Y N artificial joint/prosthesis
Y N liver problems

I UNDERSTAND that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____
(signature)

_____
(date)

Payment is due in full at the time of treatment unless prior arrangements have been approved.

4. (continued): Do you have or have you had any of the following?

Y N diabetes
Y N substance or alcohol abuse
Y N asthma
Y N epilepsy or seizures
Y N venereal disease
Y N HIV positive
Y N AIDS
Y N hepatitis
Y N tuberculosis
Y N psychiatric treatment
Y N excessive bleeding following a cut or injury
Y N anti-depression Medication
Y N ulcers/colitis
Y N stomach problems
Y N kidney problems

Additional Information (List question number first, then supply the additional information)

_____

_____

_____

Section (5) DENTAL HISTORY

1. What is the reason for today's visit?_____

2. What was the date and reason for your last dental visit?
_____

3. Why have you decided to change dentists?_____

4. What did you like most about your past dental office?

_____

5. If you have lost any teeth, how have they been replaced?: Fixed bridge____ Age_____
Removable bridge____ Age_____; Denture_____ Age_____

6. Are you happy with the replacement?_____ If yes, explain:

7. Would you like permanent replacements?_____

8. Have you ever had any problems or complications with previous dental treatment? Y N
If yes, explain:

9. Do you clench or grind your teeth? Y N

10. Does you jaw click or pop? Y N

11. Are your teeth sensitive to: hot___; cold___; sweets____; pressure_____

12. Do your gums bleed or hurt? Y N If yes, when:

13. Are you happy with the appearance of your teeth?_____ Y N

14. How would you rate how you feel about your smile on a scale of 1 to 10, with 10 being highest?_____

15. Do you feel your breath is offensive at times? _____Y N

16. Have you had gum treatment or surgery? _____Y N

17. Have you had any unpleasant dental experience or is there anything about dentistry that you strongly dislike? Y N _____

Dental Home Care Used:
18. Toothbrush: Hard___ Med___ Soft___ Electric____

19. Toothpaste: Regular____ Desensitizing____ Tartar Control_____

20. Floss: Yes____ No____ Waxed____ Unwaxed____

21. Interdental Cleaners: Brush____ Pick____ Rubber Tip____

22. Other home care drugs, devices, or products: _____

23. Last cleaning appointment:_____

24. Are you deeply concerned about the finances required to return your mouth to excellent dental health? Y N_____

Additional Information (List question number first, then supply additional information)
_____ _____

_____ _____

OFFICE USE ONLY
Medical History Update

1. Date:_____ Comments:_____

Signature:_____

2. Date:_____ Comments:_____

Signature:_____

3. Date:_____ Comments:_____

Signature:_____

4. Date:_____ Comments:_____

Signature:_____

5. Date:_____ Comments:_____

Signature:_____

- End of Form -