RENFRO FAMILY DENTAL

PATIENT INFORMATION FORM

PATIENT INFORMATION

Chart# _____
FOR OFFICE USE ONLY

Patient Name*: _____ (Last) _____ (First) ____ (Mi) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/Dr/etc) Gender*: ◯ Male ◯ Female Family Status*: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date*: _____ Drivers License #: _____ Email Address: _____

Phone: _____ (Mobile) _____ (Work) _____ (Ext.) _____ (Home) Social Security #: _____

How do you prefer to receive your appointment confirmations? ◯ Text ◯ Email ◯ Phone

Address*: _____

_____ (City) _____ (State) _____ (Zip Code)

How did you hear about us?: ◯ Doctor referral ◯ Friend/Family ◯ Found on Google ◯ Found on Healthgrades/Yelp/Other

Name of person, office, or other source referring you to our practice: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for*: ◯ The patient's spouse ◯ The person responsible for payment ◯ Neither-not applicable

Patient Name*:

Title: Gender*: ◯ Male ◯ Female Family Status*: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date*: _____ Prov Visit: _____ Email Address: _____

Phone: _____ (Mobile) _____ (Work) _____ (Ext.) _____ (Home) Best time to call: _____

Address*: _____

_____ (City) _____ (State) _____ (Zip Code)

EMPLOYMENT INFORMATION

The following relates to: ◯ The patient ◯ The person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

PATIENT INFORMATION FORM

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Insured Birth Date: _____ ID# _____ Group# _____

Insured's Address: _____

_____ City _____ State _____ Zip Code

Insured's Employer Name: _____

Employer Address: _____

_____ City _____ State _____ Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ City _____ State _____ Zip Code

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured: _____

Insured Birth Date: _____ ID# _____ Group# _____

Insured's Address: _____

_____ City _____ State _____ Zip Code

Insured's Employer Name: _____

Employer Address: _____

_____ City _____ State _____ Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ City _____ State _____ Zip Code

Consent for Services

✓ *I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

✓ * I understand that all charges are due at time of service. If I have dental insurance, I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature: _____

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MEDICAL & DENTAL HISTORY FORM

Patient Name*: _____ (Last) _____ (First) ____ (Mi) _____ (Preferred Name)

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

If Yes, please explain: _____

What is the date of your last medical exam*?: _____

Please list your Primary Care Physician's name, address, & phone number*: _____ (Name)

_____

_____ (City) _____ (State) _____ (Zip Code)

Have you been hospitalized within the last 5 years due to a surgery or illness*? ◯ Yes ◯ No

If Yes, please explain: _____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ◯ Yes ◯ No Date: _____

Does your physician recommend that you take antibiotics prior to dental treatment*?: ◯ Yes ◯ No ◯ I don't know

Are you taking or scheduled to begin taking either of the medications, Fosemax or Actonel for osteoporosis or Paget's disease*?: ◯ Yes ◯ No

Please List All Medications: (prescription and non-prescription):

_____

Please list pharmacy name and phone #: _____ (Name) _____ (Phone)

Have you ever had any complications following dental treatment*?: ◯ Yes ◯ No

If Yes, please explain: _____

Do you use tobacco (smoking or chewing)?: ◯ Yes ◯ No Woman Only: Are you pregnant*?: ◯ Yes ◯ No

If Yes, when is the due date?: _____

Please check any of the following that apply to you:

- ◯ * Pre - Med - Amox
- ◯ *Pre - Med - Clind
- ◯ *Pre - Med - Other
- ◯ Allergies
- ◯ Allergy - Aspirin
- ◯ Allergy - Codeine
- ◯ Allergy - Erythro
- ◯ Allergy - Hay Fever
- ◯ Allergy - Latex
- ◯ Allergy - Other
- ◯ Allergy - Penicillin
- ◯ Allergy - Sulfa
- ◯ Anemia
- ◯ Anesthetic – no vaso
- ◯ Arthritis
- ◯ Artificial Joints
- ◯ Asthma
- ◯ Back Problems
- ◯ Blood Disease
- ◯ Cancer
- ◯ Crohn's
- ◯ Diabetes
- ◯ Dizziness
- ◯ Epilepsy
- ◯ Excesive Bleeding
- ◯ Fainting
- ◯ Glaucoma
- ◯ Head Injuries
- ◯ Headaches
- ◯ Heart Disease
- ◯ Heart Murmur
- ◯ Hepatitis
- ◯ High Blood Pressure
- ◯ HIV
- ◯ Jaundice
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Lupus
- ◯ Mental Disorders
- ◯ MVP
- ◯ Nervous Disorders
- ◯ Other
- ◯ Pacemaker
- ◯ Pregnancy
- ◯ Radiation Treatment
- ◯ Respiratory Problems
- ◯ Rheumatic Fever
- ◯ Rheumatism
- ◯ Shingles
- ◯ Sinus Problems
- ◯ Stomach Problems
- ◯ Stroke
- ◯ Thyroid Problems
- ◯ Tuberculosis
- ◯ Tumors
- ◯ Ulcers
- ◯ Venerreal Disease

MEDICAL & DENTAL HISTORY FORM

Are you in any discomfort now*?: ◯ Yes ◯ No

Please check any of the following problems that apply:

◯ Discomfort, clicking or popping in jaw
◯ Red, swollen or bleeding gums
◯ Sensitive tooth, teeth or gums
◯ Blisters/Sores in or around the mouth
◯ Lost/Broken Filling(s)
◯ Teeth grinding/clenching
◯ Ringing in ears
◯ Broken/Chipped Tooth
◯ Stained teeth
◯ Locking Jaw
◯ Bad Breath
◯ Other

When was your last dental visit*?: _____

Prior Dentist's name, address, & phone number: _____
Name

_____

_____ _____ _____
City State Zip Code

_____
Phone Number

How frequently do you brush your teeth?

◯ 3(+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1(+) a day ◯ 2-6 weekly ◯ 1-6 monthly ◯ Seldom ◯ Never

If you could change anything about your mouth, teeth, or smile, what would it be?:

✓ *To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

✓ * I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

Signature: _____ Response Date: _____

For Office Use Only: ◯ Health history reviewed by doctor.

Signature of Doctor: _____ Response Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that this facility reserves the right to change their Notice of Privacy Practices and that I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.

I would like to authorize the release of my medical/dental information to the following individuals:

_____

I authorize the doctor and staff to communicate with me via:

☑ Text Message

☑ Email

☑ Voicemail

I understand that these communications may contain medical/dental information.

Date: _____

Signature of Individual or Legal Representative: _____

Printed Name of Individual or Legal Representative: _____