VINTAGE DENTAL

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely — the better we communicate, the better we can care for you.

1 Patient Information

_____

(Last Name, First Name, M.I.)

Title : □ Mr. □ Mrs. □ Ms.

Patient Address:_____

City:_____State____Zip_____

Home Phone:_____Work:_____

Cell Phone:_____Pager:_____

Email:_____

Date of Birth:_____ Sex: □ Female □ Male

□ Single □ Married □ Divorced □ Child

SS#:_____ DMV#_____

Relationship To Responsible Party: □ Self □ Spouse □ Dependant

Reason For Appointment:_____

Referred By: _____

Patient's Employer:_____

Patient's Occupation_____

Employer's Address:_____

City:_____State____Zip_____

Financially Responsible Party

2

_____

(Last Name, First Name, M.I.)

Title: □ Mr. □ Mrs. □ Ms.

Address:_____

City:_____State___Zip_____

SS#:_____ DMV#_____

Phone:_____*Work*:_____

Date of Birth: _____

Employer: _____

Occupation_____

Employer's Address:_____

City:_____State____Zip_____

DENTAL INSURANCE

3 We will be happy to bill your insurance company for you. However, it is **EXREMELY** IMPORTANT that we have ALL of your insurance information.

Primary Carrier:

Insurance Co. Name:_____

Insured's Name:_____

Insured's S.S. _____

Insured's Employer:_____

Insured's Date of Birth:_____

Patient's Relation to Insured:_____

Group I.D._____

Do you have any other Dental Insurance?
Yes □No □

Secondary Carrier

Insurance Co. Name:_____

Insured's Name:_____

Insured's S.S. _____

Insured's Employer:_____

Insured's Date of Birth:_____

Patient's Relation to Insured:_____

Group I.D._____

FINANCIAL AGREEMENT / ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize and request my insurance company to pay directly to the doctor the amount due on my claim for services rendered to me or my dependent. ***I further agree that I am responsible for the entire amount of dental and surgical expense, should the nature of the treatment be such that it is not entirely covered by my policy.*** *A Photostat of this authorization shall be valid as the original.*

CANCELLATION / NO SHOW POLICY

I understand an appointment is a confirmation. There will be no charge to reschedule appointments providing I give 24-hour advance notice (calls must be received 8-5:00, Mon-Thurs). Otherwise ***I will be subject to a $25 per 1/2-hour fee for not showing or canceling the day of my appointment.*** *Please sign below that you have read and understand the above policies.*

Signed:_____ **Date**_____

Medical History

4

Physician: _____
Address: _____
Date of last physical exam: _____

PLEASE ANSWER ALL QUESTIONS

Have you been a patient in the hospital during the past two years? ☐Yes ☐No
If so, for what? _____
_____

Have you been under the care of a medical doctor during the past two years? ☐Yes ☐ No
If so, for what? _____
_____

Have you taken any medicine or drugs the past two years? ☐Yes ☐ No
If so, what? _____
_____
_____
_____

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ☐Yes ☐ No
If so, what? _____

Have you ever had any excessive bleeding requiring special treatment? ☐Yes ☐ No

Are you on a special diet? ☐Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐Yes ☐ No

Do you have any disease, condition, or problem not listed? ☐Yes ☐ No

Do you have any type of non-dental implant (ie: breast, chin, cheek, etc.)? ☐ Yes ☐ No

Do you require pre-medication? ☐Yes ☐ No

WOMEN: Are you pregnant now? ☐Yes ☐No

Are you taking birth control pills? ☐Yes ☐No

Do you anticipate becoming pregnant? ☐Yes ☐No

Medical History

5 Have you ever had any of the following medical problems?

√CHECK APPROPRIATE BOX FOR ALL CONDITIONS

Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Artifical Joint
☐	☐	Heart Disease or Attack	☐	☐	Rheumatism
☐	☐	Heart Murmur	☐	☐	Arthritis
☐	☐	Rheumatic Fever	☐	☐	Nervousness
☐	☐	Artificial Heart Valve	☐	☐	AIDS/HIV
☐	☐	Heart Pacemaker	☐	☐	Bruise Easily
☐	☐	Hepatitis	☐	☐	Emphysema
☐	☐	Cancer Treatment	☐	☐	Asthma
☐	☐	Psychiatric Treatment	☐	☐	Cough
☐	☐	Pain in Jaw Joints	☐	☐	Sinus Trouble
☐	☐	Tuberculosis	☐	☐	Stroke
☐	☐	Yellow Jaundice	☐	☐	Diabetes
☐	☐	Kidney Trouble	☐	☐	Hay Fever
☐	☐	High Cholesterol	☐	☐	Hemophilia
☐	☐	Blood Transfusion	☐	☐	Sickle Cell
☐	☐	Thyroid Disease	☐	☐	Epilepsy or Seizures
☐	☐	Fainting or Dizzy Spells			
☐	☐	Allergic To Latex	☐	☐	Glaucoma
☐	☐	Allergic To Tape	☐	☐	Anemia
☐	☐	Allergic To Golds or Metals			

To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health or if my medicines change, I will inform the Doctor of Dentistry at the next appointment without fail.

I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or X-rays, as may be deemed necessary by the Doctor of Dentistry in attendance.

I authorize the Doctor of Dentistry to release any information including diagnosis and the records of any treatment or examination to me or my child during the period of such Dental Care to the third party payer's and/or health practioner's.

_____ _____
Date Signature of Patient or Guardian

_____ _____
Date Doctor's Signature