Petras FAMILY DENTAL

Welcome to our dental practice! We appreciate the opportunity to help you with your dental needs. Providing this information helps us to treat you safely and efficiently. All information provided is confidential.*

Patient Name_____

Preferred Name _____

Birthdate(mm/dd/yyyy)_____ Age ___

Street Address_____

City _____

Postal Code_____

Employer_____

Occupation _____

Home Phone_____

Cell Phone_____

Email_____

Preferred method of contact: ☐ Phone ☐ Email

RESPONSIBLE PARENT/GUARDIAN (If patient is a minor):

Name _____

Relationship to patient_____

EMERGENCY CONTACT:

Name _____

Phone Number _____

Relationship to patient_____

Who may we thank for referring you to our office?

_____

Referrals are always appreciated!

PRIMARY INSURANCE INFORMATION (If applicable)

Name of policyholder _____

Birthdate of policyholder(mm/dd/yyyy)_____

Policy Number _____

Subscriber ID Number _____

Insurance Company _____

Place of Employment_____

Relationship of patient to policy holder:

Self / Spouse / Dependent (please circle)

☐ ☐ ☐

SECONDARY INSURANCE INFORMATION (If applicable)

Name of policyholder _____

Birthdate of policyholder(mm/dd/yyyy)_____

Policy Number _____

Subscriber ID Number _____

Insurance Company _____

Place of Employment_____

Relationship of patient to policy holder:

Self / Spouse / Dependent (please circle)

☐ ☐ ☐

****Please hand insurance card(s) to receptionist now.****

Payment is due on treatment date if not covered by your insurance plan. Overdue accounts are subject to a 1.75% charge per month (minimum charge of $5 per month). I agree to cover any and all collect costs, if necessary.

Insurance plans are confidential agreement between you and your insurance company. Written estimates can be provided to assist in processing of your dental benefits. You are responsible for any amount not covered by your dental plan.

I certify that the medical information provided on the following form is accurate and correct to the best of my knowledge.

I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described, to the named dentist.

Our office wants to assist you and all our patients by minimizing wait times between appointments. Last minute cancellations or no shows delay your treatment and the treatment for other patients who could have used that appointment time. **We require 48 hours notice to cancel or reschedule an appointment to avoid a $40.00 cancellation fee**.

I consent to the release of information as set out in our privacy policy.

_____

Signature of patient, parent or guardian

Date_____

The following information is required for our dental professionals to provide you with the safest possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the form as completely as possible. The dentist will review the questions and explain any questions that you do not understand

- Are you currently being treated for any medical condition at the present, or within the past year? ☐ Yes / No ☐

_____

_____

2. When was your last medical checkup?_____

Was there any specific findings?

_____

_____

Name of your Medical Doctor:_____

- Are you currently taking any medications, non-prescription drugs, or herbal supplements?

_____

_____

If yes, please list pharmacy:

_____

- Do you have any allergies? Use the following categories:

Medications: _____

Latex/rubber/metals: _____

Other (hayfever, foods, etc.) _____

Do any of these allergies lead to breathing problems?

_____

- Do you have any reactions to dental injections? ☐ Yes / No ☐
- Do you have, or ever had asthma? ☐ Yes / No ☐
- Do you have emphysema, bronchitis, or COPD? ☐ Yes / No ☐
- Do you have, or had blood pressure problems? ☐ Yes / No ☐
- Do you have, or ever had any chest pain? ☐ Yes / No ☐
- History of heart valve replacement or repair? ☐ Yes / No ☐
- Have you ever had total joint replacement? ☐ Yes / No ☐
- Have you ever had a heart attack in the past? ☐ Yes / No ☐
- Have you ever had a stroke in the past? ☐ Yes / No ☐
- Do you have a pacemaker inserted? ☐ Yes / No ☐
- Do you have, or ever had leukemia? ☐ Yes / No ☐
- Do you have, or ever had HIV or AIDS? ☐ Yes / No ☐
- Do you have, or ever had hepatitis? ☐ Yes / No ☐
- Do you have, or ever had cancer? ☐ Yes / No ☐
- Do you have, or ever had radiation therapy? ☐ Yes / No ☐
- Do you have, or ever had chemotherapy? ☐ Yes / No ☐
- Do you have, or ever had osteoporosis? ☐ Yes / No ☐
- Have you taken bisphosphonate meds? ☐ Yes / No ☐
- Have you taken any meds to strengthen bones? ☐ Yes / No ☐
- Are you currently taking any steroid therapy? ☐ Yes / No ☐
- Do you have a bleeding disorder? ☐ Yes / No ☐
- Have you ever been diagnosed with diabetes? ☐ Yes / No ☐
- Do you have kidney disease or transplant? ☐ Yes / No ☐
- Do you have, or ever had stomach ulcers? ☐ Yes / No ☐
- Do you have, or ever had a seizure before? ☐ Yes / No ☐
- Do you have, or ever had tuberculosis? ☐ Yes / No ☐
- Any other medical concerns not listed above?

_____

_____

_____

- Have you ever been hospitalized for any reason (include year)?

_____

_____

- Do you smoke or chew tobacco? ☐ Yes / No ☐
- Do you have, or had drug/alcohol dependency? ☐ Yes / No ☐
- Are you nervous during dental treatment? ☐ Yes / No ☐
- Date of last dental treatment? _____
- Any dental concerns that we should know?

_____

_____

_____

- For women only:
  - Are you currently pregnant? ☐ Yes / No ☐
  - Are you currently breastfeeding? ☐ Yes / No ☐
  - Are you taking an oral contraceptive? ☐ Yes / No ☐

Petras FAMILY DENTAL

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Email: petrasfamilydental@gmail.com

Dr. _____

I, _____ have recently become a patient of Petras Family Dental.
Patient Name (please print)

Please provide them with a paper or digital copy of:

☐ Date of last new patient/recall exam.

☐ Date of last BW radiographs (please provide a copy if less than 1 year old)

☐ Date of last Panoramic radiograph (please provide a copy if less than 3 years old)

☐ Copy of progress notes

Please forward digital chart/radiographs to petrasfamilydental@gmail.com or provide on CD.

I authorize the release of all requested dental records to Petras Family Dental.

_____
Patient Name (please print)

_____
Patient Signature

_____
Date