IMPLANT SURGERY CENTER

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Home Phone (____) _____ Alt. Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ Email _____

City _____ State _____ Zip _____

Sex [ ] M [ ] F Age _____ Birthdate _____ [ ] Married [ ] Widowed [ ] Single [ ] Minor
[ ] Separated [ ] Divorced [ ] Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? [ ] Yes [ ] No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please Complete Both Sides.

IMPLANT SURGERY CENTER

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check [X] if you have had problems with any of the following:

[ ] Bad breath
[ ] Bleeding gums
[ ] Clicking or popping jaw
[ ] Food collection between teeth
[ ] Grinding teeth
[ ] Loose teeth or broken fillings
[ ] Periodontal treatment
[ ] Sensitivity to cold
[ ] Sensitivity to hot
[ ] Sensitivity to sweets
[ ] Sensitivity when biting
[ ] Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronal, Boniva. [ ] Yes [ ] No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of lonumin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). [ ] Yes [ ] No

Have you had any serious illnesses or operations [ ] Yes [ ] No If yes, describe _____

Have you ever had a blood transfusion [ ] Yes [ ] No If yes, give approximate dates _____

(Women) Are you pregnant? [ ] Yes [ ] No Nursing? [ ] Yes [ ] No Taking birth control pills? [ ] Yes [ ] No

Check [X] if you have or have had any of the following:

[ ] Anemia
[ ] Arthritis, Rheumatisim
[ ] Artificial Heart Valves
[ ] Artificial Joints
[ ] Asthma
[ ] Back Problems
[ ] Blood Disease
[ ] Cancer
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Circulatory Problems
[ ] Cortisone Treatments
[ ] Cough Persistent
[ ] Cough up Blood
[ ] Diabetes
[ ] Epilepsy
[ ] Fainting
[ ] Glaucoma
[ ] Headaches
[ ] Heart Murmur
[ ] Heart Problems
[ ] Hemophilia
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Jaw Pain
[ ] Kidney Disease
[ ] Liver Disease
[ ] Mitral Valve Prolapse
[ ] Pacemaker
[ ] Radiation Treatment
[ ] Respiratory Disease
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Shortness of Breath
[ ] Skin Rash
[ ] Stroke
[ ] Swelling of Feet or Ankles
[ ] Thyroid Problems
[ ] Tobacco Habit
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Ulcer
[ ] Venereal Disease

MEDICATIONS: List medications you are currently taking:

_____

_____

_____

ALLERGIES

_____

_____

_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year form the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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