PATIENT INFORMATION

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as thoroughly 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.

Date: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Social Security #: _____
Last First Middle Initial

Address_____City_____State_____Zip_____

Sex M F Age _____ Date of Birth _____ Patients Email Address _____

☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partnered ☐ Minor

Patient Employer/School Occupation _____ Who may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone_____

PRIMARY DENTAL INSURANCE

Person Responsible for Account: _____
Last First Middle Initial

Relationship to Patient _____ Date of Birth _____ Social Security # _____

Address (If different from patient) _____Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____ Business Phone _____

Insurance Company _____ Phone # _____ Group # _____ Subscriber # _____

Authorization for Submission of Claim, Assignment of Benefits, Release of Records and Financial Policies

I authorize Rolling Acres Dentistry to submit claims for payment of service to the dental care service plans or insurance company's names below on my behalf in my name and assign to such provide the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services.

I authorize Rolling Acres Dentistry to release to hospital or car service plans, insurance companies, self-insurers, or their representatives, all info and records including x-rays about my dental history, or about services rendered or treatment given to me, that is needed to review, investigate, or evaluate claims for benefits. My coverage is under a group master agreement held by my employer, an associate trust fund, or union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization will remain in effect up to 5 years from this date. I know I have a right to receive a copy of this authorization if requested.

I understand that I am financially responsible for any changes NOT covered by the group insurance benefits. I have read and understand the office and financial policies.

Patient Name: _____ Insurance Carrier (If applicable) _____

Signature of Patient or Guardian _____

Consent of Treatment

1. I hereby authorize doctors or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of (name of patient) _____, s dental needs.
2. Upon such a diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
3. I agree to use anesthetic, sedative, and other medication as necessary. I fully understand that suing anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.

Patient's Signature _____ Date _____

Signature of Patient or Guardian _____ Relationship to Patient _____

Patient Name: _____ Date: _____

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Y N If Yes _____

Have you ever been hospitalized or had a major operation? Y N If Yes _____

Have You ever had a serious head or neck injury? Y N If Yes _____

Are you taking any medication, pills or drugs? Y N If Yes _____

Do you take, or have you taken, Phen-Fen or Redux? Y N If Yes _____

Have you taken Forsamax, Boniva, Actonel, blood thinners or any other medications containing Bisphosphonates? Y N If Yes _____

Are you on a special diet? Y N If Yes _____

Do you use tobacco? Y N If Yes _____

Do you use controlled substances? Y N If Yes _____

Women: Are you… ○ Pregnant or trying ○ Nursing ○ Taking Oral contraceptives

Are you allergic to any of the following? **Please circle**

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics Other? _____

Do you have, or have you had any of the following?

AIDS/HIV Positive	Y N	Cortisone Medicine	Y N	Hemophilia	Y N	Radiation Treatment	Y N
Alzheimer's Disease	Y N	Diabetes	Y N	Hepatitis A	Y N	Recent Weight Loss	Y N
Anaphylaxis	Y N	Drug Addiction	Y N	Hepatitis B or C	Y N	Renal Dialysis	Y N
Anemia	Y N	Easily Winded	Y N	Herpes	Y N	Rheumatic Fever	Y N
Angina	Y N	Emphysema	Y N	High Blood Pressure	Y N	Rheumatism	Y N
Arthritis/Grout	Y N	Epilepsy or Seizures	Y N	High Cholesterol	Y N	Scarlet Fever	Y N
Artificial Heart Valve	Y N	Excessive Bleeding	Y N	Hives or Rash	Y N	Shingles	Y N
Artificial Joint	Y N	Excessive Thirst	Y N	Hypoglycemia	Y N	Sickle Cell Disease	Y N
Asthma	Y N	Fainting Spells	Y N	Irregular Heartbeat	Y N	Sinus Trouble	Y N
Blood Disease	Y N	Frequent Cough	Y N	Kidney Problems	Y N	Spina Bifida	Y N
Blood Transfusion	Y N	Frequent Diarrhea	Y N	Leukemia	Y N	Stomach Problems	Y N
Breathing Problems	Y N	Frequent Headaches	Y N	Liver Disease	Y N	Stroke	Y N
Bruise Easily	Y N	Genital Herpes	Y N	Low Blood Pressure	Y N	Swelling of Limbs	Y N
Cancer	Y N	Glaucoma	Y N	Lung Disease	Y N	Thyroid Disease	Y N
Chemotherapy	Y N	Hay Fever	Y N	Mital Valve Prolapse	Y N	Tonsillitis	Y N
Chest Pains	Y N	Heart Attack/Failure	Y N	Osteoporosis	Y N	Tuberculosis	Y N
Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N	Jaw Pain	Y N	Tumors or Growths	Y N
Congenital Heart Disorder	Y N	Heart Pacemaker	Y N	Parathyroid Disease	Y N	Ulcers	Y N
Convulsions	Y N	Heart Trouble/Disease	Y N	Psychiatric Care	Y N	Venereal Disease	Y N
						Yellow Jaundice	Y N

Have you ever had any serious illness not listed above? Y N If Yes: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature, Parent or Guardian: _____ Date: _____