New Patient Form

PATIENT INFORMATION

NAME: _____ SSN: _____
LAST FIRST INITIAL

ADDRESS: _____ HOME PHONE: _____
CITY STATE ZIP

CELL PHONE:_____ EMAIL ADRESS: _____ DOB: _____/_____/_____

SEX: □ MALE □ FEMALE MARITAL STATUS: □ SINGLE □ MARRIED □ CHILD

EMPLOYER: _____ OCCUPATION: _____ BUSINESS PHONE: _____

HOW DID YOU FIND US? □ REFERRED BY A FRIEND:_____ □ ONLINE □ OTHER:_____

HAVE YOU SEEN US ON: □ FACEBOOK □ TWITTER □ GOOGLE REVIEWS

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____
LAST FIRST INITIAL

EMPLOYER (If different from patient): _____ SSN: _____ BIRTHDATE: ____/____/_____

ADDRESS (If different from patient): _____ HOME PHONE: _____

WORK PHONE: _____ CELL PHONE: _____IF PATIENT IS A CHILD, THE CHILD RESIDES WITH: _____

ASSIGNMENT AND RELEASE

I, undersigned, certify that I (or my dependent) has insurance coverage with _____ insurance company, and assign directly to Raben Dentistry 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, AND THAT ANY CO-PAYMENTS OR NON-COVERED SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. I understand that my insurance will be filed at no charge for the first filing. Additional requests from myself or my insurance company may be assessed an administrative charge. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF REPONSIBLE PARTY: _____ DATE: _____

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges incurred for treatment of myself of my dependent. I UNDERSTAND THAT ALL FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED, AND AGREE TO MAKE PAYMENT. Finance charge: Payment is due when services are rendered. A FINANCE CHARGE will be charged on all past due accounts. The FINANCE CHARGE is 1.5% per month, which is an ANNUAL PERCENTAGE of 18%. There is a $1.00 per month minimum FINANCE CHARGE for accounts not paid in full. All returned checks are subject to a $30.00 returned check fee. **Your appointments in our office are times that we reserve just for you. Appointments broken within 24 hours of the appointment time may be assessed a broken appointment fee.**

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

PATIENT DENTAL AND MEDICAL HISTORY Patient Name:

Previous Dentist and Location: _____ Last Dental Exam: _____

	YES	NO	DK
Do your gums bleed while brushing or flossing?	□	□	□
Are your teeth sensitive to cold, hot, sweets or pressure?	□	□	□
Do you feel pain in any of your teeth?	□	□	□
Do you have any sores or lumps in or near your mouth?	□	□	□
Have you had any head, neck or jaw injuries?	□	□	□
Have you experienced any of the following problems in your jaw:	□	□	□
Clicking?	□	□	□
Pain (joint, ear, side of face)?	□	□	□
Difficulty opening or closing?	□	□	□
Difficulty in chewing?	□	□	□

	YES	NO	DK
Do you clench or grind your teeth?	□	□	□
Do you bite your lips or cheeks frequently?	□	□	□
Have you ever had any difficult extractions?	□	□	□
Have you ever had any prolonged bleeding following extractions?	□	□	□
Do you wear dentals or partials?	□	□	□
If yes, date of placement: _____.			
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	□	□	□
Do you like your smile?	□	□	□

Physician: _____ Office Phone:_____ Date of Last Exam: _____

Other Medical Specialist:_____ Office Phone:_____ Date of Last Exam:_____

Are you under medical treatment now? □ Yes □ No

If yes, please describe _____.

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? □ Yes □ No

If yes, please describe _____.

Are you taking any medications? □ Yes □ No

If yes, what medication(s) are you taking? _____.

	YES	NO
Have you ever taken Fen-Phen/Redux?	□	□
Do you use controlled substances?	□	□
Are you wearing contact lenses?	□	□

WOMEN ONLY:	YES	NO
Are you pregnant or think you may be pregnant?	□	□
Are you nursing?	□	□
Are you taking oral contraceptives?	□	□

Are you allergic to or have any reactions to the following?

	YES	NO		YES	NO
Local anesthetic (e.g. Novocain)	□	□	Sedatives	□	□
Penicillin or any other antibiotics	□	□	Aspirin	□	□
Sulfa drugs	□	□	Any metals	□	□
Barbiturates	□	□	(e.g. nickel, mercury, etc)		
Iodine	□	□	Latex rubber	□	□
			Codeine or other narcotics	□	□

Other (please list): _____

_____.

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

	YES	NO		YES	NO		YES	NO		YES	NO
High Blood Pressure	□	□	Kidney Diseases	□	□	Arthritis	□	□	Radiation Therapy	□	□
Heart Attack	□	□	AIDS or HIV Infection	□	□	Joint Replacement or Implant	□	□	Glaucoma	□	□
Rheumatic Fever	□	□	Heart Disease	□	□	Hepatitis/Jaundice	□	□	Recent Weight Loss	□	□
Swollen Ankles	□	□	Cardiac Pacemaker	□	□	Sexually Transmitted Disease	□	□	Liver Disease	□	□
Fainting/Seizures	□	□	Heart Murmur	□	□	Stomach Trouble/Ulcers	□	□	Heart Trouble	□	□
Asthma	□	□	Angina	□	□	Chest Pains	□	□	Respiratory Problem	□	□
Low Blood Pressure	□	□	Frequently Tired	□	□	Easily Winded	□	□	Mitral Valve Prolapse	□	□
Epilepsy/Convulsions	□	□	Anemia	□	□	Stroke	□	□	Other (Please List):_____		
Leukemia	□	□	Emphysema	□	□	Hay Fever/Allergies	□	□	_____		
Diabetes	□	□	Cancer	□	□	Tuberculosis			_____		

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYABLE TO ME.

_____

Signature of patient (or parent/guardian if minor)