Rachel Oates Family Dental

A. Patient Information

Full Name ______________________________________ Preferred Name ________________________

Gender: Male/Female Status: (circle) Married Single Divorced Widowed Separated

Date of Birth _______________________ Social Security _________________________________

Address ____

____

Email Address ____

Phone Number _______________________________ Additional Line ________________________

Employer Name ______________________________

If self pay (no insurance), initial line and skip to section D. ____________

B. Insurance Information

Name of Insured __________________________________ Gender: Male/Female

Date of Birth of Insured ____________________________ Relationship _______________________

Social Security of Insured ___________________________

Address (If different): ____

Phone Number ____

Employer of Insured ____

C. Insurance Policy Information

If Insurance is Delta, Ameritas, Guardian, or Metlife:

Social Security Number of Policy Holder ____

If Insurance is Humana, Aetna, Bluecross, United Healthcare, Cigna :

ID # ____________________________ Group # ________________________

Secondary Insurance

Name of Insurance Plan ______________________________

ID # ____________________________ Group # ________________________

Social Security Number _________________________

D. Spouse or Responsible Party Information for Patient

Name _______________________________________ Gender: Male/Female Relationship __________

Phone Number ________________________________ Employer ____________________________

Email Address ______________________________________

E. Financial Policy

Thank you for choosing our office for your dental health care. We accept cash, personal checks, Mastercard, Visa, American Express, and Care Credit. Payment is due at the time service is provided. Note that returned checks will be subject to additional fees. If necessary for our office to enlist a collection service or legal assistance, you will be held responsible for collection and legal charges incurred. All appointments broken less than 48 hrs in advance or in which you do not show will be charged a $50 penalty fee. I have received a copy of the full financial policy in addition to these items, and I have read, understand and agree to the terms and conditions.

Signature _______________________________________ Date ____________________

F. Privacy Policy

I received a copy of the Notice of Privacy Policy of Rachel Oates Family Dental under direct cooperation with HIPAA. I authorize the use and disclosure of my protected health information for any necessary clinical, financial, and insurance purposes. I received a copy of the full privacy policy and I have read, understand and agree to the terms and conditions.

Signature _______________________________________ Date ____________________

G. Referral Information

How or from whom did you hear about us? ____

H. Medical and Dental History

Primary Reason for this dental appointment: (circle) Examination Emergency Consultation

List any specific dental concerns ____

List any specific questions you would like your hygienist or doctor to discuss________________________

Name of current primary care physician and location ____

Have you been hospitalized or had a major operation? No/Yes_________________________________

Have you had a serious injury to the head or neck? No/Yes____________________________________

Have you received radiation to the head or neck? No/Yes_____________________________________

Have you ever taken bisphosphonates (Actonel, Aredia, Boniva, Fosamax, Zometa, Bonefos, Ostac, Skelid, Didronel)? No/Yes____

Are you allergic to any medications or substances? ____

Specifically: (circle) Aspirin Penicillin Codeine Acrylic Metals Latex Red Dye Cinnamon

Please list any and all medications, pills, or drugs you currently take:______________________________

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Have you taken antibiotic premedication prior to dental appointments in the past? No/Yes_______________

Heart Trouble/Disease	**Yes No**	Hemophilia	**Yes No**	Frequent Diarrhea	**Yes No**	HIV Positive	**Yes No**
Heart Murmur	**Yes No**	Leukemia	**Yes No**	Diabetes	**Yes No**	Genital Herpes	**Yes No**
Irregular Heart Beat	**Yes No**	Recent Blood Transfusion	**Yes No**	Excessive Thirst	**Yes No**	Drug Addiction	**Yes No**
Angina/Chest Pain	**Yes No**	Swelling of Limbs	**Yes No**	Hypoglycemia	**Yes No**	Cold Sores	**Yes No**
Heart Attack/Failure	**Yes No**	Lung Disease	**Yes No**	Liver Disease	**Yes No**	Fever Blisters	**Yes No**
Congenital Heart Disorder	**Yes No**	Breathing Problem	**Yes No**	Hepatitis A	**Yes No**	Herpes	**Yes No**
Mitral Valve Prolapse	**Yes No**	Shortness of Breath	**Yes No**	Hepatitis B or C	**Yes No**	Stroke	**Yes No**
Scarlet Fever	**Yes No**	Frequent Cough	**Yes No**	Yellow Jaundice	**Yes No**	Convulsions	**Yes No**
Rheumatic Fever	**Yes No**	Hay Fever	**Yes No**	Kidney Problems	**Yes No**	Epilepsy / Seizures	**Yes No**
Artificial Heart Valve	**Yes No**	Sinus Trouble	**Yes No**	Renal Dialysis	**Yes No**	Fainting / Dizziness	**Yes No**
Heart Pace Maker*	**Yes No**	Asthma	**Yes No**	Thyroid Disease	**Yes No**	Glaucoma	**Yes No**
Heart Surgery	**Yes No**	Emphysema	**Yes No**	Parathyroid Disease	**Yes No**	Tumors or Growths	**Yes No**
High blood Pressure	**Yes No**	Tuberculosis	**Yes No**	Arthritis/Gout	**Yes No**	Nervousness	**Yes No**
Low Blood Pressure	**Yes No**	Cancer	**Yes No**	Rheumatism	**Yes No**	Psychiatric Care	**Yes No**
Blood Disease	**Yes No**	Radiation	**Yes No**	Pain in Jaw Joints	**Yes No**	Alzheimer's Disease	**Yes No**
Bruise Easily	**Yes No**	Chemotherapy	**Yes No**	Cortisone Medicine	**Yes No**	Allergies(Medicine)	**Yes No**
Anemia	**Yes No**	Stomach/Intestinal Disease	**Yes No**	Artificial Joint	**Yes No**	Allergies(Pollen/Dust)	**Yes No**
Excessive Bleeding	**Yes No**	Ulcers	**Yes No**	Venereal Disease	**Yes No**	Hives or Rash	**Yes.No**
Sickle Cell Disease	**Yes.No**	Recent Weight Loss	**Yes.No**	AIDS	**Yes.No**		

List other serious illnesses or medical concerns not addressed above_______________________________

To the best of my knowledge, all of the the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Signature ____ Date ______________________

Signature of Provider ______________________________ Date ______________________