Patient Information

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Personal

Name ______________________________
Last First MI (Preferred)

Birthdate ______________ SS# ______________ Gender: ❑ M ❑ F Married: ❑ Yes ❑ No

Address ______________________________

Address 2 ______________________________ Check box if same for entire family ❑

City ______________ State ______________ Zip ______________

Work Phone# ______________ Cell Phone# ______________ Home Phone# ______________

Which phone is preferred? ❑ Work ❑ Cell ❑ Home Email ______________

Preferred contact method for appointment confirmations and reminders ❑ Text ❑ Email ❑ Phone Call

How did you hear about us? (If someone referred you here, please write down their name so we can thank them.)

____

Insurance Policy 1

Please present insurance card to receptionist.

Relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Subscriber Name ______________

Subscriber ID # ______________ DOB ______________

Insurance Company ______________

Phone ______________

Employer ______________

Group Name ______________ Group # ______________

Insurance Policy 2

Please present insurance card to receptionist.

Relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Subscriber Name ______________

Subscriber ID # ______________ DOB ______________

Insurance Company ______________

Phone ______________

Employer ______________

Group Name ______________ Group # ______________

Medical History

Name of Medical Doctor ______________ City/State ______________

Emergency Contact ______________ Phone ______________ Relationship ______________

Pharmacy of choice ______________ Phone ______________

List any medical conditions you may have

❑ asthma
❑ bleeding problems
❑ cancer
❑ diabetes
❑ heart murmur
❑ heart trouble
❑ high blood pressure
❑ HIV / AIDS
❑ joint replacement
❑ kidney or liver disease
❑ pregnancy
❑ psychiatric treatment
❑ sinus trouble
❑ stroke
❑ history of rheumatic fever
❑ taken any osteoporosis meds
❑ thyroid problems
❑ tobacco use
❑ other ______________

List all the medications or drugs you are NOW TAKING:

❑ None ______________

List all the medications or drugs you are ALLERGIC TO:

❑ None ______________

❑ Yes ❑ No Have you ever been told to premedicate with antibiotics before dental treatment?

If Yes, for what condition? ______________ What exact prescription? ______________

❑ Yes ❑ No Do you have an unusual reaction to dental injections? If so, what happens? ______________

New Patients Only

❑ Yes ❑ No Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 3 years old?
❑ Yes ❑ No Do you have BiteWing x-rays that are less than 1 year old?

Name of former dentist ______________________ City/State ______________________

Date of last cleaning and exam ______________________

Dental Questions

What is the reason(s) for your visit today?

____

____

❑ Yes ❑ No Is everything comfortable in your mouth? If not, please explain ______________________

____

❑ Yes ❑ No Do you feel you have a healthy mouth? If not, please explain ______________________

____

❑ Yes ❑ No Are you happy with the appearance of your teeth? If not, please explain ______________________

____

❑ Yes ❑ No Are you able to eat, speak, swallow and function properly? If not, please explain ______________________

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Financial and Scheduling Agreement

- As a courtesy to our patients we will contact you 2 weeks before you appointment to confirm this reserved time. Any changes to the schedule can be made at this time.
- We ask you provide us with a minimum of 2 business days notice for any changes to appointments. (We do not accept changes after hours or by voice mail)
- I understand I am responsible for all dental services rendered. If I have dental insurance, Andler Dental may forward my information to my insurance company, and receive payment directly from them.
- Every effort will be made to help me estimate my insurance contribution, but if they do not pay as expected, I will still be responsible for any remaining balance.
- We kindly request any co-payments to be paid at the time of service.
- I agree to pay finance charges of 1.5% per month (18%APR) on any balance 90 days past due and if sent to collections, I agree to pay all related fees and costs.

Signature ______________________ Date ______________________

Notice of Privacy Policies

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature ______________________ Date ______________________