Steve Douglas DDS – Patient Medical & Dental Info Date:___/___/____

Name: _____ Nickname:_____ Date of Birth:____/____/____ Age ____

Address:_____ Apt/Suite: _____ Home # (____)_____-_____

City:_____ State ____Zip_____ Work # (____)_____-_____

Social Security #_____-____-_____ Marital Status: M D S W Sex: M F Cell # (____)_____-_____

FT Student: Y N Retired: Y N Employer:_____ Occupation:_____

New Patients: Who referred you to our office? _____

If you are a new patient OR your insurance/payment info changed since your last visit, then complete this section.

Primary-Dental Insurance: Name:_____
Dental ID #:_____ Group #_____ (attach copy)
Subscriber's Name:_____ Relationship to Patient:_____
Social Security:_____-_____-_____ Date of Birth:____/_____/_____
Employer:_____ Dental Claims Phone#_____
Dental Claims Address:_____

Secondary-Dental Insurance: Name:_____
Dental ID #:_____ Group #_____ (attach copy)
Subscriber's Name:_____ Relationship to Patient:_____
Social Security:_____-_____-_____ Date of Birth:____/_____/_____
Employer:_____ Dental Claims Phone#_____
Dental Claims Address:_____

Who is the person responsible for the bill? _____
Address (if different than above):_____City_____Zip_____
Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____

All Patients- Treatment Authorization and Acknowledgements:

I consent to treatment as necessary or desirable to the care of the patient named above, for the diagnosis of dental disease, deformity or treatment of a dental emergency. These procedures may include radiography, models and intraoral examination. In the case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance.

The professional or medical expense benefits allowable and otherwise payable to me under the current insurance policy, will be used as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee. A photocopy of the assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

Payment is expected at the time of services rendered unless prior arrangements are made. Payments are accepted by cash, check, MC/Visa/Discover/AMEX and Care Credit per approval. Insurance forms will be filed but patient out-of-pocket expenses are expected at time of services. The patient is also responsible for services not covered by the insurance company, including any differences in what the insurance company does not cover and our fee.

A twenty-four (24) hour notice is required in order to avoid a charge for failed appointments. Dismissal from the practice may result after three failed appointments or failure to pay within a timely manner.

The undersigned agrees that all past due accounts shall be charged 1.75% interest per month on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility or all collection agency fees, attorney fees, court costs and any other costs incurred while collecting the amount due.

Signature of Responsible Party:_____ Date: _____/_____/_____

Steve Douglas DDS – Patient Medical & Dental Info Date:___/___/____

Patient Name:_____ **Date**:____/____/_____

Dental Info: How often do you brush? _____ How often do you floss?_____

Yes No Do you have a specific problem which needs immediate attention?_____

Yes No Have you needed or appreciated Nitrous Oxide (laughing gas) with past treatments?

Yes No Do you have braces? If so, who is your orthodontist? _____

Yes No Does your jaw click or pop while opening AND/OR cause you pain?

Yes No Do you suffer from frequent headaches AND/OR ringing in your ears?

Yes No Has a doctor asked you to Pre-Medicate for your dental visits? What antibiotic?_____

Dr's Name:_____ Dr's Phone: (____)_____-_____

Reason for Pre-Med?_____

When was last dental visit? _____

If at previous dentist, please provide DDS name & phone #_____

What would you like us to know about your past dental care/experiences &/OR do you have any dental concerns?

_____

_____

Medical Information: Please complete in order to provide you the best comprehensive dental treatment. Some conditions could affect your dental and oral conditions, thus altering your treatment needs.

Do you have OR ever had ANY of the following? (Please check and note which if multiple choices)

O Abnormal Bleeding	O Cancer/Chemo	O Fever Blisters	O HIV/AIDS	O Seizures
O Addiction	O Colitis	O Frequent Headaches	O Kidney Disease	O Shingles
O Allergies	O Diabetes	O Heart Attack	O Liver Disease	O Sinus Problems
O Arthritis	Last A1C _____	O Heart Surgery	O Low Blood Pressure	O Stroke
O Artificial Bone/Joint	O Difficulty Breathing	O Hemophilia	O Psychiatric Treatment	O Thyroid Problems
O Asthma	O Epilepsy	O Hep A or B or C	O Radiation Therapy	O Tuberculosis
O Blood Transfusion	O Fainting Spells	O High Blood Pressure	O Reflux	O Ulcers

Explain & date above conditions & any other problems we should know prior to treatment:

_____

_____

Are you under the care of a physician now? Explain: _____

Physician Name: _____ Phone Number (_____)_____-_____

List ALL allergies to medications? _____

List ALL prescribed & over-the-counter medications or supplements you are currently taking:

_____

_____

Do you smoke/chew/vape? Which and how often? _____

Women are you… 1. Taking birth Control? Y or N 2. Pregnant? Y or N (___wks pregnant) 3. Nursing? Y or N

I hereby certify that the above info is accurate and complete to the best of my knowledge. (Revised 15Aug2018)

Patient or guardian's signature:_____Date: _____/_____/_____