PETZNICK DENTAL
GENERAL AND AESTHETIC DENTISTRY

Patient Information

Today's Date _____

Last Name _____ **First Name** _____ **MI** _____ **Preferred Name**_____

DOB _____ **Gender** M or F **Family Status** Single Married Child Other **Soc. Sec. #** _____

Home Phone (_____)_____ **Cell Phone** (_____)_____ **Work Phone** (_____)_____

Best Time To Call _____ **Email** _____ **Preferred Contact Method** _____

Mailing Address _____ **City** _____ **State** ____ **Zip Code** _____

Driver's License # _____**Occupation**_____ **Employer**_____

Emergency Contact _____ **Relationship** _____ **Phone #** (_____)_____

Name of person, office, or other source referring you to our practice_____

Reason for today's visit? _____

Head of Household / Responsible Party Information

Last Name _____ **First Name** _____ **MI** _____ **Preferred Name**_____

DOB_____ **Relationship** _____ **Soc. Sec. #** _____ **Driver's License #** _____

Phone # (_____)_____ **Email** _____ **Preferred Contact Method** _____

Mailing Address _____ **City** _____ **State** ____ **Zip Code** _____

Occupation _____ **Employer**_____

Primary Dental Insurance

Name of Insured _____

Insured's DOB _____

Insured's Address_____

Insured's Employer_____

Patient's Relationship to Insured _____

Insurance Co_____

Insurance Co Address _____

Insurance Phone # _____

Contract/ID # _____

Plan Group #_____

Secondary Dental Insurance

Name of Insured _____

Insured's DOB _____

Insured's Address_____

Insured's Employer_____

Patient's Relationship to Insured _____

Insurance Co_____

Insurance Co Address _____

Insurance Phone # _____

Contract/ID # _____

Plan Group #_____

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date _____

Relationship to Patient: _____

Cancellation Policy

As a courtesy to our office and our patients we request at least a 48-hour notice of cancellations.

This will allow us time to offer your reserved appointment to another patient who may be waiting for an appointment and could also be in pain. We are understanding of unforeseen circumstances that may come up.

Thank you so much for your understanding and compliance with this policy.

Signature:_____ Date _____

PETZNICK DENTAL
GENERAL AND AESTHETIC DENTISTRY

Dental & Medical History Form

Last Name _____ **First Name** _____ **MI** _____ **DOB** _____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Dental Information

What is the reason for your dental visit today? _____

When was your last visit to the dentist (if to a different office)? _____

What was done on your last dental visit (if to a different office)? _____

Date of last dental x-rays? _____ **Prior Dentist's Name, address, & phone #** _____

_____

How frequently do you brush your teeth? ☐ 3(+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss your teeth? ☐ 1(+) a day ☐ 2 – 6 weekly ☐ 1 – 6 monthly ☐ Seldom ☐ Never

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you brux or grind your teeth?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?
- ☐ Have you had any periodontal (gum) treatments?
- ☐ Have you ever had orthodontic treatment?
- ☐ Do you have any clicking, popping or discomfort in the jaw?
- ☐ Is your mouth dry?
- ☐ Do you have sores or ulcers in your mouth?

If any of the previous questions are marked, please explain: _____

_____

Medical Information

Would you consider yourself to be in fairly good health? ☐ Yes ☐ No

Within the past year, have there been any changes in your general health? ☐ Yes ☐ No

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name, address, & phone _____

_____

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain: _____

_____

Please indicate if you have experienced any of the following:

☐ Pre-Med – Amox	☐ Pre-Med – Clind	☐ Pre-Med – Other	☐ Allergies
☐ Allergy – Aspirin	☐ Allergy – Codeine	☐ Allergy – Erythro	☐ Allergy – Hay Fever
☐ Allergy – Latex	☐ Allergy – Other	☐ Allergy – Penicillin	☐ Allegy – Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis A
☐ Hepatitis B	☐ Hepatitis C	☐ High Blood Pressure	☐ HIV
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Mitral Valve Prolapse	☐ Nervous Disorders	☐ Other	☐ Pacemaker
☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Thyroid Disease	☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Venereal Disease			

Women Only: Are you pregnant or nursing? Pregnant? ☐ **Yes** ☐ **No** ☐ **Unsure** **Nursing?** ☐ **Yes** ☐ **No**

If Pregnant, when is the due date? _____

Do you have any other health issues or allergies? If So, please explain. _____

_____

List of current medications (If you have a printed list with you please feel free to give to the receptionist for her to copy)_____

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian (responsible party):

Signature: _____ **Date** _____

Relationship to Patient: _____