STERLING DENTAL

PATIENT INFORMATION FORM

ABOUT YOU

Today's Date _____

Name _____
LAST FIRST MI

I prefer to be called _____ Male Female

Birth Date ____ / ____ / ____ SS# _____ - _____ - _____

Mailing Address _____

_____
CITY STATE ZIP CODE

SINGLE MARRIED DIVORCED WIDOWED SEPARATED

HOME # _____ CELL# _____

Employer's Name _____

Phone # _____ How long there? _____

Best time and # to reach you _____

Whom may we thank for referring you?

_____

Other family members seen by us?

_____

Last visit date _____

Do you allow appointment reminders by email? Y N

SPOUSE INFORMATION

His / Her Name _____

Employer _____

Work # _____

Birth Date _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____

Home # _____ Work # _____

Billing Address _____

Relationship _____ SS# _____

Employer _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Insured's DOB ____ / ____ / ____ Relation _____

Insured's SSN _____

Insured's Employer _____

DENTAL HISTORY

Why are you seeking services today? _____

_____

_____

Have you taken Bisphosphonates?

Fosamax Actonel Boniva

YES or NO Start Date _____ End Date _____

Do you require antibiotics before dental treatment? **Y N**

Are you currently in pain? **Y N**

Have you ever had a serious / difficult problem associated with any previous dental work? **Y N**

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ / TMD) **Y N**

Your current dental health is? Good Fair Poor

Do you like your smile? **Y N**

Do your gums bleed? **Y N**

How many times a week do you floss? _____

Type of bristles you are using? Hard Medium Soft

Have you ever taken Phen-Fen? **Y N**
(also known as Redux or Pondimin)

If so when? _____

Any condition we should know about _____

_____

HEALTH HISTORY FORM

Do you have a personal physician? Y N

Physician's Name _____

Phone # _____ Last Visit _____

Do you have any of the following?

Frequent Heavy Snoring? Y N

Significant daytime drowsiness? Y N

Tendency to stop breathing while sleeping? Y N

Shortness of breath when waking from sleep? Y N

Not feeling refreshed in the morning? Y N

Morning headaches? Y N

Overall, do you feel fatigue Y N

Are you currently seeing an OBGYN physician? Y N

Physician's Name _____

Phone # _____ Last Visit _____

Are you taking over the counter or prescription drugs? Y N

Please List _____

_____

Do you smoke or use tobacco in any form? Y N

For Women:

Are you taking Birth Control Pills? Y N

Are you pregnant? Y N

Your Physical Health is? Good Fair Poor

ARE YOU ALLERGIC TO THE FOLLOWING?

ASPRIN	Y N	ERYTHROMYCIN	Y N	PENICILLIN	Y N
CODEINE	Y N	JEWELRY/METALS	Y N	TETRACYCLINE	Y N
DENTAL ANESTHETICS	Y N	LATEX	Y N	OTHER	Y N

Please list any other drugs / materials that you have allergies to _____

_____

Have you ever had any of the following disease or medical problems?

Anemia/Radiation Treatment	Y N	Hemophilia/Abnormal Bleeding	Y N
Artificial/Joints/Valves	Y N	Hepatitis	Y N
Arthritis	Y N	High/low Blood Pressure	Y N
Alcohol Abuse/ Counseling	Y N	HIV/Aids	Y N
Blood Transfusion	Y N	Hospitalized for any reason	Y N
Cancer/Chemotherapy	Y N	Kidney/Liver Problems	Y N
Congenital Heart Defect	Y N	Mitral Valve Prolapse	Y N
Diabetes	Y N	Psychiatric Problems	Y N
Difficulty Breathing	Y N	Rheumatic/Scarlet Fever	Y N
Drug Abuse/Counseling	Y N	Severe/Frequent Headaches	Y N
Emphysema/Glaucoma	Y N	Shingles	Y N
Epilepsy/Seizures/Fainting Spells	Y N	Sickle Cell Disease/Traits	Y N
Fever Blisters/Herpes	Y N	Sinus Problems	Y N
Glaucoma	Y N	Thyroid Problems	Y N
Heat Attack/Stroke	Y N	Tuberculosis (TB)	Y N
Heart Murmur	Y N	Ulcers/Colitis	Y N
Heart Surgery/Pacemaker	Y N	Venereal Disease	Y N

EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her name _____ Relationship _____

Home phone # _____ Cell / Work #_____

CONSENT FOR TREATMENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Payment is due in full at time of service or treatment unless prior arrangements have been approved.

_____ _____

Signature Date

COLLECTIONS

I understand that in the event any unpaid balance is placed for collections with any third-party collection agency, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in the addition to any other costs incurred directly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 50% and the additional costs and charges listed above represent the actual costs incurred by Sterling Dental to collect amounts owed under this agreement and corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in the agreement.

_____ _____

Signature Date

Notice of Privacy Practice

Our office is HIPAA compliant and committed to meeting or exceeding all standards to protect your information. If there is anyone you would like to grant access to your dental records, including treatment and appointments, please list them below.

_____ _____

Signature Date

I authorize my information to be shared with my insurance company, pharmacy, and/or physician's office(s)

_____ _____

Signature Date