



PLATINUM DENTAL

Insurance Information

Relation to policy holder: Self Spouse Child

Dental Insurance- 1st Coverage

Policy Holder
Policy Holder Date of Birth
Name of Insurance Co.
Address
Telephone
I.D or policy #
Group #

Dental Insurance- 2nd Coverage

Policy Holder
Policy Holder Date of Birth
Name of Insurance Co.
Address
Telephone
I.D or policy #
Group #

Patient Information

First Name: M.I.
Last Name:
Preferred Name:
Sex: F M Date of Birth: / /
SS#
Driver's Lic.#
Email:
Address
City: State: Zip:
Hm # ( ) -
Wk # ( ) - Ext.
Cell ( ) -
Patient/Parent Employer
Present Position:
Referred by: Phonebook Website Location Other
Patient
In case of emergency who should be notified?
Phone:

Responsible Party

Who will be responsible for the account? Self (if self you don't need to fill out this section) Father Mother Other
Name: Soc. Sec. # D.L.#
Date of Birth ' / / Hm Tel.# ( ) - Cell # ( ) -
Address: City: State: Zip
Employer: Tel.:( ) -

Smile Evaluation

Do you like the appearance of your teeth? Yes No Do you smoke or chew? Yes No
If no, please explain Are your teeth all in alignment (straight)? Yes No
Do you have dental examinations on routine basis? Yes No Do you have spaces you don't like? Yes No
Are there old fillings or dental work you don't like looking at? Yes No Do you like the color of your teeth? Yes No
Do you ever have clicking/popping/discomfort in the jaw joint? Yes No Do you snore? Yes No
Do you clinch or grind your teeth? Yes No Do you brush and floss daily? Yes No
Have your past dental experiences been positive? Yes No Do your gums ever bleed? Yes No
Do you have specific dental problems? Yes No Have you ever been treated for gum disease? Yes No
When was the last full mouth series of x-rays taken? When is the last time you had your teeth cleaned?
Name of previous dentist:

Patient Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

### Medical Information

Reason for today's office visit:  
\_\_\_\_\_

Name of your Physician:  
\_\_\_\_\_

Phone: \_\_\_\_\_

Have you had any illness, operation or been hospitalized in the past five years?  
\_\_\_\_\_

Are you taking any medication? Y  N

Please List  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications or substances?

Latex  Penicillin  Codeine  Sulfa

Aspirin  Acrylic  Metal

Other \_\_\_\_\_

#### Women

Pregnant/trying to get pregnant Y  N

Nursing Y  N

Taking oral contraceptives Y  N

### Health History

Heart Trouble/Disease	Yes	No	Irregular Heart Beat	Yes	No
Angina/ Chest Pain	Yes	No	Heart Attack/ Failure	Yes	No
Congenital Heart Disorder	Yes	No	Mitral Valve Prolapse	Yes	No
Heart Murmur	Yes	No	Anemia	Yes	No
Scarlet Fever	Yes	No	Artificial Heart Valve	Yes	No
Heart Pace Maker	Yes	No	Heart Surgery	Yes	No
High Blood Pressure	Yes	No	Blood Disease	Yes	No
Tuberculosis	Yes	No	Diabetes	Yes	No
Epilepsy/ Seizure	Yes	No	Asthma	Yes	No
Rheumatic Fever	Yes	No	Artificial joint, prosthesis	Yes	No
Shortness of Breath	Yes	No	Sickle Cell Disease	Yes	No
Leukemia	Yes	No	Recent Blood Transfusion	Yes	No
Chemotherapy	Yes	No	Lung Disease	Yes	No
Emphysema	Yes	No	Cancer	Yes	No
Ulcers	Yes	No	Excessive Thirst	Yes	No
Liver Disease	Yes	No	Hepatitis A (infectious)	Yes	No
Hepatitis B or C	Yes	No	Pain in Jaw Joints	Yes	No
Cortisone Medicine	Yes	No	AIDS	Yes	No
HIV Positive	Yes	No	Drug Addiction/Alcoholism	Yes	No
Kidney Problems	Yes	No	Renal Dialysis	Yes	No
Thyroid Disease	Yes	No	Stroke	Yes	No
Cold Sores/Fever Blisters	Yes	No	Fainting or Dizziness	Yes	No
Tumors or Growths	Yes	No	Nervousness	Yes	No
Psychiatric Care	Yes	No	Alzheimer's Disease	Yes	No
Allergies (Medicines)	Yes	No	Allergies (Pollen/Dust)	Yes	No
Need Premedication?	Yes	No	Sleep Apnea	Yes	No

Have you ever had any serious illness not listed above?  
\_\_\_\_\_

Do you wish to talk to the dentist privately about anything?  
\_\_\_\_\_

I **Certify** that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member if his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient: \_\_\_\_\_

(Parent or Guardian if minor) **X**

Date: \_\_\_\_\_

### Fees & Payment

We make every effort to keep down the cost of your dental treatment. You can help by paying upon completion of each visit. An estimate of the charge for any procedure you may require will be given to you upon request. If you have dental insurance we will be glad to fill out the proper forms and file them, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys' fees, and court costs.**

Signature of Patient: \_\_\_\_\_

(Parent or Guardian if minor) **X**

Date: \_\_\_\_\_

### Authorization for Assignment of Benefits

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient: \_\_\_\_\_

(Parent or Guardian if minor) **X**

Date: \_\_\_\_\_

### Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient: \_\_\_\_\_

(Parent or Guardian if minor) **X**

Date: \_\_\_\_\_