

# Patient Information

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as thoroughly as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Date \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Name \_\_\_\_\_ ID#/Soc Sec # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Please provide your E-Mail address if you wish to receive information from us about future promotions, newsletters, education materials, etc.:

Patient's E-mail Address \_\_\_\_\_

Married  Widowed  Single  Separated  Divorced  Partnered for \_\_\_\_\_ years Minor

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone ( ) \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Please provide the name of any person or persons you wish to grant permission to Tioga Dental Associates the ability to discuss personal, insurance, financial or dental treatment plan information with (i.e., spouse, parent, guardian, other relative, etc.)

Whom may we thank for referring you? \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Person Responsible for Account: \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ ID#/Soc Sec # \_\_\_\_\_

Address (If different from Patient's) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Contract # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

## INSURANCE AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Tioga Dental Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. Tioga Dental Associates may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

**PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED**

### ADDITIONAL INSURANCE (MEDICAL OR DENTAL)

Person Responsible for Account: \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ ID#/Soc Sec # \_\_\_\_\_

Address (If different from Patient's) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Contract # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

**Please complete other side**

**DENTAL HISTORY**

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Address \_\_\_\_\_

Check (✓) If you have had problems with any of the following:

- Bad Breath  Bleeding gums  Clicking or popping jaw  Food collection between teeth  Grinding teeth
- Loose teeth or broken fillings  Periodontal treatment  Sensitivity to cold  Sensitivity to hot
- Sensitivity to sweets  Sensitivity when biting  Sores or growths in your mouth

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These includes combinations of Lonimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Do you currently (or have you in the past) taken any Bisphosphonates (e.g. Boniva, Fosamax, Actonel)?  Yes  No

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No • Nursing?  Yes  No • Taking birth control?  Yes  No

Check (✓) If you have had problems with any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |

**MEDICATIONS**

List Medications you are currently taking below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES**

List Allergies you have below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY FORM AUTHORIZATION**

Please provide your signature below to indicate you have completed this medical history form to the best of your knowledge and ability and have provided to TIOGA DENTAL ASSOCIATES accurate and thorough information regarding your medical history and contact information. We are required to ask you to update this form once every 12 months:

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date