

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 & ORTHODONTICS 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 & ORTHODONTICS 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 & ORTHODONTICS 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"/> Implants (hip, knee, etc) |

MEDICATIONS

List Medications you are currently taking below:

ALLERGIES

List Allergies:

Other

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 & ORTHODONTICS 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