ENCORE
FAMILY DENTISTRY

PATIENT INFORMATION

DATE:___/___/___

NAME: _____ **O** MINOR **O** MALE **O** FEMALE
LAST FIRST MIDDLE

SOCIAL SECURITY #: _____ BIRTHDAY: ___/___/___ **O** MARRIED **O** SINGLE

ADDRESS: _____
STREET CITY STATE ZIP

TELEPHONE: _____ _____ _____
CELL # WORK # HOME #

EMAIL: _____

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____

PERSON RESPONSIBLE FOR ACCOUNT – (PLEASE CHECK ONE): **O** PATIENT **O** GUARDIAN **O** SPOUSE **O** FATHER **O** MOTHER

INSURANCE INFORMATION

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED

PRIMARY INSURED/ IF NO INSURANCE, COMPLETE FOR RESPONSIBLE PARTY	**PERSON TO CONTACT IN CASE OF EMERGENCY (Outside of Immediate Family Household – unless patient is a minor)**
LAST FIRST MIDDLE	NAME
STREET CITY STATE ZIP	ADDRESS
CELL # HOME#	CITY STATE ZIP
BIRTHDAY (MONTH/DAY/YEAR) RELATIONSHIP TO PATIENT	TELEPHONE #
EMPLOYER DENTAL INSURANCE COMPANY	RELATIONSHIP TO PATIENT
SOCIAL SECURITY # SUBSCRIBER # GROUP #	

Has any member of your family ever been treated in our office? **O** Yes **O** No
If so, list name(s): _____

Primary reason for this dental appointment: **O** Examination **O** Emergency **O** Consultation

Preferred Pharmacy: _____ Phone #: _____

PATIENT NAME: _____DATE: _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X_____
PATIENT OR RENPONSIBLE PARTY DATE

Please check how you were referred to our office:

O Insurance **O** Internet **O** Doctor _____

O Patient _____

O Other _____

METHOD OF PAYMENT

O Payment in full at each appointment
(cash or personal check)

O Payment in full at each appointment
(**O** VISA **O** MC **O** OTHER)

Card #_____ Exp. Date_____

SERVICE CHARGE

If I do not pay the entire new balance within **10** days of the monthly billing date, a service charge will be added to the account for the current monthly billing period.

The service charge will be a periodic rate of **1.5%** per month (or a minimum charge of **$7.00** for a balance under **$100.00**) which is an annual percentage rate of **18%** applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

BROKEN APPOINTMENT FEE

There will be a $50.00 broken appointment fee for all appointments not cancelled 24 hours in advance.

X_____
PATIENT OR RESPONSIBLE PARTY DATE

PATIENT NAME: _____ DATE: _____

DENTAL HISTORY

	YES	NO
Do you have dental examinations on a routine basis? Date of last visit?		
Name of previous dentist:		
Date of last full mouth x-rays (18 small films (FMX) or panoramic):		
Do you think you have active decay or gum disease?		
Do you brush and floss on a routine basis? How often?		
Do your gums ever bleed? When / how often?		
Do you like/dislike your smile? Why?		
Does food catch between your teeth?		
Do you ever have clicking, popping or discomfort in the jaw joint?		
Do you brux or grind?		
Do you smoke or chew tobacco?		
Do you have your third molars (wisdom teeth)?		

MEDICAL HISTORY

	YES	NO
Are you under a physician's care now? Who? Phone #:		
Have you ever been hospitalized or had a major operation? Discuss		
Have you ever had a serious injury to your head or neck? Discuss		
Are you taking any medications, pills or drugs? Please list you medications here:		
Are you on a special diet? Discuss		

Are you allergic to any medications or substances? Please check box below:
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex Rubber O Other_____

WOMEN (Please check): O Pregnant/trying to get pregnant O Nursing O Taking oral contraceptive

Do you now have or have you ever had any of the following? (Please answer YES or NO)

	YES	NO		YES	NO		YES	NO
Heart Trouble / Disease			Bruise Easily			Emphysema		
Heart Murmur			Anemia			Tuberculosis		
Irregular Heart Beat			Excessive Bleeding			Cancer		
Angina / Chest Pain			Sickle Cell Disease			Radiation		
Heart Attack / Failure			Hemophilia (Bleeding Problem)			Chemotherapy		
Congenital Heart Disorder			Leukemia			Stomach / Intestinal Disease		
Mitral Valve Prolapse			Recent Blood Transfusion			Ulcers		
Scarlet Fever			Swelling of Limbs			Diabetes		
Rheumatic Fever			Lung Disease			Alzheimer's Disease		
Artificial Heart Valve			Breathing Problems			Hypoglycemia		
Cardiac Pacemaker			Shortness of Breath			Liver Disease		
Heart Surgery			Frequent Cough			Hepatitis A (Infectious)		
High Blood Pressure			Hives or Rash			Hepatitis B or C		
Low Blood Pressure			Sinus Trouble			Herpes		
Blood Disease			Asthma			Stroke		
Yellow Jaundice			Venereal Disease			Convulsions		
Kidney Problems			AIDS			Epilepsy or Seizures		
Renal Dialysis			HIV Positive			Fainting or Dizziness		
Thyroid Disease			Genital Herpes			Glaucoma		
Parathyroid Disease			Drug Addiction / Alcoholism			Tumors or Growths		
Arthritis / Gout			Cold Sores			Nervousness		
Rheumatism			Allergies (Medicines)			Artificial Joint		
Pain in Jaw Joints			Allergies (Pollen / Dust)			Need Pre-Med for dental work		

Have you ever had any other serious illness not checked above? Discuss_____
Do you wish to talk to the dentist privately about any problems? _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____

PATIENT SIGNATURE (PARENT OR GUARDIAN) ***DATE***