PATIENT INFORMATION

Welcome to Paradise Dental Care!

DATE: ____________________

❑ Minor ❑ Male ❑ Female

❑ Married ❑ Single ❑ Partnered

NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____
STREET APT. # CITY STATE ZIP

BIRTHDATE: ______________ PHONE: ______________ ______________
MONTH / DATE / YEAR HOME OFFICE (WITH EXTENSION)

SOCIAL SECURITY #: ______________ CELL PHONE: ______________ EMAIL: ______________

HOW DO YOU WISH TO BE ADDRESSED?______________ BEST METHOD OF CONTACT: ______________

OCCUPATION: ______________ PLACE OF EMPLOYMENT: ______________ ARE YOU A LOCAL RESIDENT? ______________

HAS DR. JONES TREATED YOU PREVIOUSLY? ______________ DO WE SEE OTHER FAMILY MEMBERS? ______________

WHY DID YOU CHOOSE OUR PRACTICE? ______________

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY/HOUSEHOLD IN CASE OF EMERGENCY

NAME: ______________ PHONE: ______________
LAST FIRST

ADDRESS____
STREET CITY STATE ZIP

PAYMENT INFORMATION

❑ **This office, as a courtesy, will file your insurance claim for you. However, as a OUT of NETWORK office, you are responsible for any balance that insurance does not pay.**

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ❑ **Patient** ❑ **Spouse** ❑ **Parent** ❑ **Other:** ______________

METHOD OF PAYMENT: ❑ **Cash or Check** ❑ **Credit Card** ❑ **Payment Plan (by application)**

DO YOU HAVE DENTAL INSURANCE? ______________ **NAME OF INSURANCE CO.:** ______________

INSURED'S NAME: ______________ **GROUP OR POLICY #:** ______________

INSURED'S DATE OF BIRTH: ______________ **SOCIAL SECURITY #:** ______________

EMPLOYER: ______________ **DO YOU HAVE DUAL COVERAGE?** ______________

AUTHORIZATION & POLICIES

- I hereby authorize payment directly to **Paradise Dental Care** of insurance benefits otherwise payable to me. **I understand that I am responsible for all costs of treatment provided.**
- I hereby authorize the practice to administer medications and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand that there are some risks inherent with medical or dental procedures, including numbing and local anesthetics.
- I understand that I am encouraged to question any aspect of my care if it has not been explained to my satisfaction. I recognize that payment (or insurance co-payment) is due at time of treatment and that a service and/or interest charge may be applied to any unpaid fees.
- I understand that **broken appointments** are not acceptable and that failure to provide **at least 24 hours notice** may result in termination of treatment without further notice and/or **a fee of $50 or more** to offset the expense of my reserved time and staffing.

______________________________ ______________
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Thank you for choosing our practice!

PATIENT NAME______________________________ **Date**__________

DENTAL HISTORY

What is the reason for today's appointment?______________________
Have you ever been told to take an antibiotic before dental treatment?__________
Are you apprehensive about dental treatment?______________________
If so, what specifically makes you uncomfortable or anxious?______________
What did you like MOST about your last dentist?______________________
What did you like LEAST about your last dentist?______________________
How can we help you have a positive dental visit?____________________
Would you like to consider a sedative for your appointments?______________

Do your gums bleed when you brush or floss?______________________
Have you ever been advised that you have gum disease?________________
Are you aware of clenching or grinding your teeth?____________________
How often do you awaken with Jaw Pain or Headaches?________________
Name of last Dentist______________ Date of last exam and xrays?__________

Are you happy with your Smile? ______________________________
Is there anything you would like to change?_________________________
Have you ever had your teeth Whitened?____________________________
Does that interest you?_______________________________________

MEDICAL HISTORY

Who is your Physician?____________ Any recent medical care?__________

Are you allergic to, or had any ill effects from the following? (Please CIRCLE)
Latex Rubber Household Bleach Metals/Jewelry
Penicillin Aspirin Codeine Dental Anesthetics "Novocaine"

Please list any other Drugs or Substances you are allergic to:
____

Please list all medications /herbs/over-the-counter drugs you are taking, and why:
1) ____
2) ____
3) ____
4)__________________________________use other side for additional...

Women (Please CIRCLE): Pregnant or Trying Nursing Using Oral Contraceptives

Do you wish to speak with Dr. Jones privately about any problem?__________

The preceding information is correct to the best of my knowledge.
If I have any changes in my health status, or medicines used,
I will inform the dentist at my next appointment.

X_________________________________ Date______________
(Patient Signature or Guardian)

Doctor's Notes/Findings___________________________________
____
____

Do you have or have you ever had any of the following? (Please CIRCLE)

Heart Disease/Surgery
Mitral Valve Prolapse
Artificial Valve/Pacemaker
Irregular Beat/Murmur
Rheumatic or Scarlet Fever
Bacterial Endocarditis
High/Low Blood Pressure
Stroke
Ulcers
Bulimia or Reflux
Thyroid Disease
Glaucoma

Joint Replacement
Transplant/Prostheses
Diabetes
Hepatitis
HIV+
Venereal/STD
Herpes or Cold Sores
Epilepsy or Seizures
Fainting or Dizziness
Breathing Problems
Emphysema or TB
Asthma or Sinusitis

Basphosphonates
(like Fosamax)
Blood Thinner Medicines
Bruise Easily/Blood Disease
Abnormal Bleeding
or Hemophilia
Liver or Kidney Problems
Leukemia
Cancer
Chemo or Radiation Therapy
Alcohol/Drug Abuse
Tobacco Use
Nervousness
Frequent Headaches
Alzheimer's Disease
Psychiatric Care

Have you ever had any other serious illness not noted above?

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THANK YOU FOR PROVIDING THIS INFORMATION TO BETTER SERVE YOUR DENTAL HEALTH NEEDS!