PATIENT INFORMATION

Patient Name_____ Date of Birth_____

Single - Married - Divorced - Separated - Widowed Male/Female

Patient Address_____ Email: _____

Patient Phone Number_____ Cell Phone_____ Work_____

Employer/School Name & Address_____

Spouse or Parents Name_____

Emergency Contact (name & phone) _____

Preferred method of contact: home / work / cell / email. Preferred appt. day/time _____

Name of Primary Insured _____Relation to Patient_____

Insurance Company_____

Whom may we thank for referring you? _____

OFFICE FINANCIAL POLICY

Our policy is to provide the best dental care we can provide to our patients. We feel that everyone benefits when office policy and financial arrangements are understood. In order that we may have a complete understanding with regard to the payment for dental services, the following is our office policy:

- Payment is due at time of service. For your convenience we accept cash, check, or major credit cards.
- If you have dental insurance, we will help you fill in necessary claim forms to obtain your benefits. However, ultimately, all fees are the patient's responsibility regardless of insurance reimbursement.
- We provide treatment based on the dental needs of a patient and not on the bases of what your insurance will or will not pay for. It is your responsibility to know the coverage and limitations of insurance specific policy.
- There will be fees applied to accounts for returned checks or bank fees. Interest charges will be applied to all past due amounts over 60 days. After 90 days your account will be turned over to our lawyers for collections. Charges will be applied to accounts submitted for collections.
- A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Your appointment is time allotted for you. Failed appointments are a waste of the doctors' time and delay the progress of your own treatment and others who could have used that time. Please be courteous with advanced notifications of cancellation and remember that in order to be able to provide prompt service for you and others it is paramount to keep your appointment and be on time.

By signing below, I have carefully read and fully understand all the statements above.

_____

Signature of patient or parent if minor Date

Dr Stephanos Tsitsis Dental Surgeon

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MEDICAL HISTORY FORM

Please answer all questions completely:

NAME: _____ DATE OF BIRTH: _____

Are you here for **EMERGENCY** care? **YES NO** Are you in pain? **YES NO** Are you in good health? **YES NO**

Please list and indicate dates for all hospitalizations and serious illnesses within the past 5 years:

_____

Physician's Name: _____ Date of Last Physical: _____

Date of last dental exam: _____ Date of last full mouth x-rays:_____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:

Have you taken or are taking any of the following medications (circle)? Aredia, Didronel, Fosamax, Actonel, Skelid or "Fen-phen" type such as Ionimin, Adipex, Fastin, Pondimin and Redux.

Allergies (including to medications) _____

Please list ALL medications you are taking now:

_____

_____

_____

_____

_____

Females Only: Are you currently pregnant? **Yes** or **No** Do you take Birth Control Pills? **Yes** or **No**

To the best of my knowledge all of the preceding answers are accurate. If I have any change in my health or if my medications change, I will immediately inform dentist at my next appointment.

Patient Signature **Date** **Patient Signature** **Date**

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DENTAL HISTORY FORM

1. What is your primary concern with your teeth/smile?

_____

2. Are you happy with the appearance of your teeth/smile?

_____

3. How would you like us to help you?

_____

_____

4. Are you anxious about having dental treatment? If so, what is your biggest concern?

_____

_____

Do you have, or have you had, any of the following?

Discomfort or pain? **Yes** or **No**

Tooth sensitivity to hot or cold? **Yes** or **No**

Headaches, earaches or neck aches? **Yes** or **No**

Problems with your jaw joints? **Yes** or **No**

Problems with your bite? **Yes** or **No**

Serious trouble associated with previous dental treatment? **Yes** or **No**

Please explain:

_____

Additional Information

Is there anything in your medical and dental history that we have not specifically asked about that we should be made aware of? If so, please explain:

_____

_____

Thank you for choosing our clinic for your dental care needs. We welcome your questions and comments and we are committed to providing exceptional dental care to all our patients. We appreciate the confidence you place in us.

_____

Signature of patient or parent if minor

Date

Signature of doctor

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