PATIENT INFORMATION

Date _____ Email _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Patient Information

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widow

Birthdate: _____ Age: _____ Soc. Sec: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Emergency contact: _____

Student Status: ☐ Full Time ☐ Part Time Emergency #: _____

Employer Name: _____ Pref. Pharmacy: _____

May we ask how you were referred to our practice: _____

Primary Insurance Information

Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Name of Insured: _____

Insured Soc. Sec. or Member ID _____

Insured Birth Date: _____

Ins. Company: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Secondary Insurance Information

Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Name of Insured: _____

Insured Soc. Sec. or Member ID _____

Insured Birth Date: _____

Ins. Company: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

PHOTOGRAPHIC RELEASE

Your initials below indicate your consent for Drs. Althouse, Carroll, & Alperin Ltd. to use, reproduce, and publish photographic or computer illustrations of your teeth/mouth for educational or marketing purposes, and you waive claim against any party based on the usage of the images, or make any claim that the use of the images defames you or constitutes an infringement of your rights to privacy, or any other right you may enjoy. It is not mandatory that you initial this paragraph, and you agree that if you choose to initial this paragraph, it is done so freely and voluntarily. **Client Initial** _____

I authorize the release of my dental records, billing, treatment information and account information to the following people:

_____

_____

I authorize for this dental office to talk with other health care providers regarding patient care/health ☐

Medical History

Are you under a physician's care now? ○ Yes ○ No

If yes, please provide the name and contact information for the physician.

_____

_____

_____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No **If yes, please list medications you are currently taking:**

_____

_____

_____

_____

_____

_____

Do you take or have you taken Fosamax or Actonel? ○ Yes ○ No _____

If taken, when and approximately how long were you taking it? _____

Are you on a special diet? ○ Yes ○ No _____

Do you use tobacco? ○ Yes ○ No _____

Do you use recreational drugs? ○ Yes ○ No _____

Do you use alcohol? ○ Yes ○ No _____

Have you ever had a reaction to Novocaine or similar anesthesia? ○ Yes ○ No _____

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

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

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

I have reviewed this Medical History. My (or the patient's) health and medications have changed as I have marked on this form. If no change, write "NO CHANGE".

Updates (Date & initial) _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

PATIENT DENTAL HISTORY

PLEASE CHECK ALL THOSE THAT APPLY

1. Bleeding gums ☐
2. Tooth sensitivity to hot or cold liquids/foods ☐
3. Tooth sensitivity to sweet or sour liquids/foods ☐
4. Painful teeth ☐
5. Sores or lumps in or near your mouth ☐
6. Previous head, neck or jaw injury ☐
7. Jaw Problems
   - Clicking ☐
   - Pain (Joint, ear, side of face) ☐
   - Difficulty in opening or closing ☐
   - Difficulty in chewing ☐
   - Sore biting or jaw muscles ☐
   - Recent tooth wear or abrasion ☐
   - Can you chew gum ☐
   - Has your bite changed in the last few years ☐
8. Frequent headaches ☐
9. Teeth clenching or grinding ☐
10. Frequent cheek or lip biting ☐
11. Difficult Extractions ☐
12. Orthodontic work (Braces) ☐
13. Prolonged bleeding following extractions ☐
14. TMJ treatment ☐
15. Periodontal treatment (Gum Treatment) ☐
16. Date of last dental exam _____ ☐
    Date of last dental X-rays _____
17. Dental problems that require immediate attention ☐

_____

18. Are you happy with your smile? _____ ☐
    If not, what would you change? _____

_____

19. Would you like your teeth to look whiter? _____

PAYMENT OPTIONS:

Payment is due at the time of the treatment. We accept cash, check, Mastercard, Visa, American Express and Discover card. Ask about financing options through Care Credit.

We are happy to file the necessary insurance forms so that you receive the full benefits of your coverage. We can make no guarantee of any estimated coverage because the insurance policy is an agreement between you and the insurance company. Our office will do everything possible to assist you in receiving the full benefits of your policy. However, we require all patients to be directly responsible for all charges. (Initial Please) _____

I agree to be responsible for and to pay all sums due and owing to Drs. Althouse, Carroll, Alperin & Casteen for the above named patient. I agree that 1.5% per month interest (18% per year) will be charged on accounts 60 days from treatment date. If this account is turned over to an agency for collection, I agree to pay all reasonable attorney's fees, court costs, & collection fees.

I authorize my insurance company to pay the above named doctors and authorize the doctors to release all information necessary to secure payment. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

_____ DATE _____

Please check this box if you do not wish to receive alert/reminders of your appointments ☐

Please check this box if you do not wish to receive marketing information and promotions ☐