Prairie Park Dental

How did you find out about our office?_________________________________

Patient Information

Last name________________________ First name________________ MI_____ Preferred name___________________

Date of birth_______-______-__________SSN_______-________-_______________ Male/Female (circle one)

Address__________________________________Apt #_______City_________________State______Zip_____________ .

Home phone______________________Work phone____________________Cell phone__________________________

Spouse__________________________________Date of birth_____-_______-_______SSN_______-______-________

Head of Household *(Carrier of insurance)*

Last name________________________ First name________________ MI_____ Preferred name___________________

Date of birth_______-______-________SSN_______-_______-_________ Male/Female (circle one)

Employer____Work phone__________________________________

Confirming

Email____ Cell Phone _______-________-__________

Emergency Contact

Name____Phone______________________Relationship_______________

Insurance Information

Name of insured____________________________________Has the insured been a patient here? YES/NO

Insurance Company___________________________Group #____________________ID# ________________________

Address______________________________City____________State______Zip_________Phone___________________

As a condition of treatment of the above listed patient, I understand that financial arrangements must be made in advance. Charges incurred for treatment of the above listed patient are my responsibility and are due at the time services are rendered.

Cancellation policy

A 24 hour notice of appointment cancellation is required to avoid an office visit fee.

initial here _____

If your cancellation is not within 24 hour notice of the scheduled appointment, but you do call and cancel before, on the same day of the scheduled appointment, you will receive a day of service cancellation fee.

initial here _____

Insurance Filing

I understand that the Practice will submit insurance claims for me and I agree to pay an estimated portion computed by Practice personnel on the date services are rendered. I authorize the Practice to release information regarding my treatment for the purposes of filing for potential payment of insurance benefits and I further grant assignment of any such proceeds of benefits to the Practice. Any remaining outstanding balance not paid within 60 days of date of service (the “waiting period”) will then be subject to finance charges.

Signature___________________________________Date______-______-______Relationship to patient______________________

Patient's Health History

Condition			Condition			Condition		
Anemia	YES	NO	Heart Disease	YES	NO	Radiation Treatment	YES	NO
Arthritis	YES	NO	Heart Murmur	YES	NO	Respiratory Problems	YES	NO
Artificial Joints	YES	NO	Hepatitis	YES	NO	Rheumatic Fever	YES	NO
Asthma	YES	NO	High Blood Pressure	YES	NO	Rheumatism	YES	NO
Blood Disease	YES	NO	HIV	YES	NO	Sinus Problems	YES	NO
Cancer	YES	NO	Immune Sys Disorders	YES	NO	Stomach Problems	YES	NO
Diabetes	YES	NO	Jaundice	YES	NO	Stroke	YES	NO
Dizziness	YES	NO	Kidney Disease	YES	NO	Tuberculosis	YES	NO
Epilepsy	YES	NO	Liver Disease	YES	NO	Tumors	YES	NO
Excessive Bleeding	YES	NO	Mental Disorders	YES	NO	Ulcers	YES	NO
Fainting	YES	NO	Mitral Valve Prolapsed	YES	NO	Venereal Disease	YES	NO
Glaucoma	YES	NO	Nervous Disorders	YES	NO	Codeine Allergy	YES	NO
Growths	YES	NO	Pacemaker	YES	NO	Latex Allergy	YES	NO
Hay Fever	YES	NO	Pregnant	YES	NO	Penicillin Allergy	YES	NO
Head Injuries	YES	NO	Pre-Medication	YES	NO	Other Allergies	YES	NO

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1. Are you under medical care at this time?______________________________Yes No
2. Have you been hospitalized during the last 5 years?____________________Yes No
3. Are you taking any medications at this time? (please list all) Yes No

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4. Are there any dental concerns/problems?_____________________________Yes No
5. Teeth sensitive to hot/cold or sweet/sour. (please circle)
6. Have you had orthodontic treatment? Present/Past (please circle)
7. Do you clench or grind teeth?______________________________________Yes No
8. Have you had prolonged bleeding after surgery/lacerations?______________Yes No
9. Do you frequently have a bad taste in your mouth?_______________________Yes No
10. Do you frequently have a dry mouth?_________________________________Yes No
11. Do you smoke or chew tobacco?_____________________________________Yes No
12. When was the last time you had a professional dental cleaning?____________

Other medical or dental concerns past or present?________________________________

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