New Patient Forms

Date: __________________

Patient's Name: ____
First Middle Last

If Child: Parent or Guardian Name: ____________________________________ Relation: ___________________

Address: ____ Apt #: _____________

City: _________________________________ State: __________ Zip: _________________

Home Phone: ________________________ Work: ______________________ Cell: ______________________

Patient's Social Security #: _________________________________ Date of Birth: ___________________

Sex: (check one) **M** **F** Status: (check one) **Single** **Married** **Widowed** **Child**

E-Mail Address: ____

Emergency Contact: ____ Phone: _______________________

How did you hear about our office? ____

Do you have **Dental Insurance**: **YES** **NO**

Primary Dental Insurance

Subscriber's Name: ___________________________________

Subscriber's ID or SSN: ____________________________

Subscriber's Date of Birth: ____________________________

Relationship to Patient: _______________________________

Subscriber's Employer: ________________________________

Group #: ____

Insurance Company: ________________________________

Phone: ____

Secondary Dental Insurance

Subscriber's Name: ____________________________

Subscriber's ID or SSN: ________________________

Subscriber's Date of Birth: ______________________

Relationship to Patient: _________________________

Subscriber's Employer: __________________________

Group #: ____________________________________

Insurance Company: ____________________________

Phone: _______________________________________

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New Patient Forms

PATIENT'S MEDICAL HISTORY

Physician' Name & Phone: ______________________________________ Date of Last Exam: _____________

Do you or have you had any of the following:

YES / NO Anemia / Hemophilia
YES / NO Angina / Chest Pains
YES / NO Anxiety / Nervous Problems
YES / NO Arthritis
YES / NO Asthma
YES / NO Cancer
YES / NO Chemical Dependency
YES / NO Circulatory Problems
YES / NO Diabetes: Type I or II
YES / NO Epilepsy / Seizures
YES / NO Excessive Bleeding
YES / NO Heart Attack
Date: ___________
YES / NO Heart Murmur
YES / NO Heart Surgery
Date: ___________
YES / NO Hepatitis (type A B C)
YES / NO High Blood Pressure
YES / NO High Cholesterol
YES / NO HIV / AIDS

YES / NO Joint Replacement
Date: ___________
YES / NO Kidney Disease
YES / NO Liver Disease
YES / NO Mitral Valve Prolapse (MVP)
YES / NO Osteoporosis
YES / NO Pacemaker
YES / NO Psychiatric Care
YES / NO Radiation / Chemotherapy
YES / NO Respiratory Problems
YES / NO Rheumatic Fever
YES / NO Stomach / Intestinal Disease
YES / NO Stroke
Date: ___________
YES / NO Thyroid Problems
YES / NO Tuberculosis
YES / NO Ulcers / Cold Sores
YES / NO Venereal Disease
YES / NO Family history of Diabetes
YES / NO Family history of Heart Disease

Other: ____

ALLERGIES: (circle all that apply): Penicillin Aspirin Codeine Latex Sulfa Anesthetics Other Allergies ________________ NONE

Do you smoke? YES NO
Packs per day? ________

Do you use alcoholic beverages? YES NO
Drinks per week? __________

Are you pregnant? YES NO # of weeks: ______

List all medications you are currently taking: ____

____

Please describe any current medical treatment, impending operations or any other medical
Information that may possibly affect your dental treatment: ____

____

____

New Patient Forms

PATIENT'S DENTAL HISTORY:

Reason for today's visit: ____

Date of last dental visit: ________________ What was done then: _________________________________

How many times a day do you brush your teeth? _______________ Floss? _________________

YES / NO Do your gums bleed?
YES / NO Are your gums sore or swollen?
YES / NO Have your gums receded?
YES / NO Are your teeth loose
YES / NO Do you have unexplained numbness or pain?
Face / Neck / Mouth / Ears
YES / NO Following problems in your jaw?
Clicking / Pain
YES / NO Do you clench or grind your teeth?
YES / NO Difficulty in opening or closing
YES / NO Difficulty in chewing
YES / NO Are your teeth sensitive to hot or cold liquids or foods?
YES / NO Do you snore or have been told you snore?
YES / NO Do you have a lump or thickening in the cheek?
YES / NO Do you have a sore or lesion on the lips or mouth that has persisted for 2 weeks or more?
YES / NO Have you ever had periodontal treatment (gums)?
YES / NO Do you wear dentures or partials? Age of the existing dentures or partials _______________
YES / NO Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

____

____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

____ Date ______________________
Signature of Patient or Parent/Guardian if minor

New Patient Forms

PATIENT'S FINANCIAL AGREEMENT

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

In order to be impartial to everyone, WE REQUIRE PAYMENT AT THE TIME OF THE TREATMENT. We ask that you read and sign this statement prior to any treatment. YOUR CO-PAY AND DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF THE TREATMENT. We accept cash, checks, Visa, MasterCard, Discover, and American Express. For extensive treatment plans, we offer extended payment plans with CareCredit at either little or no interest with prior credit approval.

REGARDING INSURANCE

I, the undersigned patient, understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

As a courtesy, our office will file claims to your insurance. However, your insurance is a contract between you and your insurance company. Insurance companies frequently reimburse at a lower rate than we estimate. When this occurs you may be required to pay an additional "after insurance" balance.

I authorize Biggio Dental Care to release any dental information necessary to process dental insurance claims. I also request and authorize payments of any benefits, applicable to services rendered, to Biggio Dental Care.

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment to our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

MISSED APPOINTMENTS

For you to achieve your optimal dental health, we will depend on you to schedule and keep your dental appointments. Your appointment time is very important to you and our staff. We ask that you notify our office at **least 24 – 48 hours** in advance if you cannot keep your scheduled appointment Our policy for any missed appointments is the charge of a normal office visit and this charge will be applied to your account.

____ Date ___________________________

Signature of Patient or Parent/Guardian if minor