



WELCOME TO SURRATT FAMILY DENTAL

PATIENT INFORMATION

Name: _____ Who may we thank for referring you?: _____
 Gender: M F Address: _____ City/State/Zip: _____
 Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____
 Email: _____ Best time to reach you: _____
 Birthdate: _____ Age: _____ SSN#: _____
 Patient or Parent/Guardian's Employer: _____ Occupation: _____
 If student, name of school/college: _____ City: _____ State: _____ Full-Time Part-Time
 Minor Single Married Divorced Widowed Separated
 Spouse or Parent/Guardian's Name: _____ Employer: _____
 Work phone: (____) _____ Cell phone: (____) _____ Email: _____

RESPONSIBLE PARTY

(If someone other than the patient is responsible for the account)

Name of Person Responsible for Patient: _____ Phone: (____) _____
 Relationship to Patient: _____ Is this person currently a patient in our office? Y N
 Address: _____ City/State/Zip: _____ Birthdate: _____
 Email: _____ Driver's License #: _____ SSN#: _____

INSURANCE INFORMATION

Name of insured: _____ Birthdate: _____ SSN#: _____
 Relationship to Patient _____ Name of Employer: _____
 Address of Employer: _____ City/State/Zip: _____ Work Phone: (____) _____
 Insurance company: _____ Grp #: _____ ID#: _____
 Insurance Company Address: _____ Ins Co. Phone: (____) _____



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MEDICAL HISTORY

Physician _____ Office Phone: (____) _____ Date of Last Exam: _____

Are you under a medical treatment care now? Y N
If yes, please explain: _____

Have you ever been hospitalized or had a surgical operation or serious illness within the last five years? Y N
If yes, please explain: _____

Are you taking any medication(s), including non-prescription medicine? Y N
If yes, what medication(s) are you taking?: _____

Do you take, or have you taken, Phen-Fen or Redux? Y N

Do you take, or have you taken, Fosmax, Bondhus, Actonel or any cancer medications constringing bisphosphonates? Y N
If yes, what medication(s) are you taking?: _____

Do you use tobacco? Y N

Do you use controlled substances? Y N

Are you wearing contact lenses? Y N

Are you allergic or have had any reactions to any of the following?

Aspirin Penicillin Metal(s) Latex Rubber Local Anesthetics Sulfa Drugs Barbiturates
Sedatives Iodine Other If other, please explain: _____

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? If yes, please explain: _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Trouble/Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting Spells/ | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint Replacement or |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Implant |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Kidney Diseases |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> STDs | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Ulcers |



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Have you ever had any serious illness not listed above? Y N

If yes, please explain: _____

Other comments: _____

Women ONLY: _____

Are you pregnant or think you may be pregnant? Y N

Are you taking oral contraceptives? Y N

Are you nursing? Y N

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Location: _____ Date of Last Exam: _____

Do your gums bleed while brushing or flossing? Y N

Are your teeth sensitive to hot or cold liquids/foods? Y N

Are your teeth sensitive to sweet or sour liquids/foods? Y N

Do you feel pain to any of your teeth? Y N

Do you have any sores or bumps in or near your mouth? Y N

Have you had any head, neck, or jaw injuries? Y N

Do you have frequent headaches? Y N

Do you clench or grind your teeth? Y N

Do you bite your lips or cheeks frequently? Y N

Have you ever had any difficult extractions in the past? Y N

Have you ever had any prolonged bleeding following extractions? Y N

Have you had any orthodontic treatment? Y N

Do you wear dentures or partials? Y N

If yes, what was the date of placement?: _____

Have you ever received oral hygiene instructions regarding Y N

the care of your teeth and gums? Y N

Do you like your smile? Y N

Have you ever experienced any of the following problems in your jaw? Y N

Clicking Y N

Pain (join, ear, side of face) Y N

Difficulty in opening or closing Y N

Difficulty in chewing Y N

Signature needed _____

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 their party paers others payable ot me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be resonspible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

FINANCIAL POLICY

Welcome and thank you for choosing our office for your dental care. In order to dedicate our attention to providing you the highest quality of dental care, our office has the following financial policies.

DENTAL INSURANCE: As a courtesy, we file your primary dental insurance claims for services rendered in this office. Proof of insurance is necessary so that we can file your claims. We do not file secondary or medical insurance, but will be happy to give you the proper information for you to file. Due to the wide range of dental insurance companies and benefit packages, we cannot possibly know the specific details of each and every policy. We suggest that you familiarize yourself with your dental benefit package, including: deductible, co-payment and annual maximum benefits. Co-payments are expected at the time of service. Should your claim be denied or payment is less than expected, your balance is due in full.

PAYMENT: Payment is expected at the time of service. We gladly accept cash, personal checks, Visa, Master Card, Discover, American Express and Care Credit. Also, most medical spending accounts include dental services. Any special payment arrangements must be approved by our office manager.

NOTICE OF PRIVACY PRACTICES

I understand that under the **Health Insurance Portability & Accountability Act of 1996 (HIP-PA)**. I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I understand the financial and privacy practice

Patient Name _____

Signature _____

Date _____