Medical Information

Patient Name: _____ Today's Date: _____

PERSONAL INFORMATION

Please fill out as accurately as possible

Do you have a Primary Care Dr.? ☐Yes ☐No If Yes _____

Have you been hospitalized or had a major operation? ☐Yes ☐No If Yes _____

Have you ever had a serious head or neck injury? ☐Yes ☐No If Yes _____

Are you currently taking any medications? ☐Yes ☐No If Yes _____

Do you have any allergies to medications? ☐Yes ☐No If Yes _____

Have you ever taken Fosamax, Boniva Actonel, or any other medications containing bisphosphonates? ☐Yes ☐No If Yes _____

The following information is needed to accurately diagnose any condition and to give the highest possible standard of professional service. Please answer honestly and accurately.

Do you have or have you ever had any of the following diseases or problems?

	Yes	No		Yes	No
Arthritis	☐	☐	Kidney Disease	☐	☐
Blood disorders, anemia, problems clotting	☐	☐	Breathing disorder, Asthma etc.	☐	☐
Cancer/Tumors	☐	☐	Nervous disorders	☐	☐
Heart Disease/Heart Murmur	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Heart Attack/ Stroke?	☐	☐	Seizures	☐	☐
High or Low blood pressure	☐	☐	Sinus problems	☐	☐
Hepatitis (A, B, C) Jaundice or Liver disease	☐	☐	Tuberculosis (TB)	☐	☐
Thyroid disease	☐	☐	Ulcers	☐	☐
HIV or AIDS	☐	☐	Do you smoke or use tobacco	☐	☐
Joint replacement (s)	☐	☐	History of substance abuse	☐	☐
Are you pregnant/ Nursing?	☐	☐	Diabetes Type____	☐	☐

If you answered ***Yes*** to any of the above, please give further details: _____

_____

Any other allergies or illnesses not listed above? _____

List any additional medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Signature Date Dr.'s Signature

PATIENT INFORMATION:

Today's Date: _____/_____/_____

Home Phone: _____ Cell Number: _____

Name: _____ SSN #_____

Address: _____City: _____ St: _____ Zip Code: _____

Sex: M ___ F ___ Birthday: _____ Minor___ Single___ Married___

Parent/Patient Employer: _____ Work Number: _____

Patient email: _____

Pharmacy Name & Number (or address) _____

Emergency Information:

Please list two people to contact in case of an emergency. One CANNOT live with you; (it does not have to be a relative) and the other can be your spouse/significant other:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Responsible Party: (The person paying on the account. *Not* your insurance.)

Name: _____ D.O.B: _____ SSN # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Work number: _____

Has anyone in your family been in our office? _____ Name: _____

Dental Insurance Information:

Policy Holder's Name: _____ D.O.B: _____ SSN # _____

Insurance Company: _____ Phone: _____

Insured's Employer: _____ Phone: _____

Group # _____ Subscriber/ID # _____

Is the patient covered by a secondary dental insurance? Do you have two dental insurances? Y ___ N __

Policy Holder's Name: _____ D.O.B: _____ SSN # _____

Insurance Company: _____ Phone: _____

Insured's Employer: _____ Phone: _____

Group # _____ Subscriber/ID # _____

CONSENT FOR TREATMENT

I authorize *Dr. Goldberg D.D.S* and/or assistants as s/he may designate to perform those procedures that may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause a reaction or side effects, which may include, but are not limited to bruising, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may in rare cases, require bronchoscope or other procedures to ensure safe removal. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____

Initials

HIPAA PATIENT CONSENT

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing. The practice provides this form to comply with the Health Insurance Portability Accountability Act 1996 (HIPPA). A detailed description of the HIPAA policy is available for you upon request.

_____

Initials

OFFICE FINANCIAL POLICY

1. Our office provides insurance claim submission as a courtesy to our patients. You are directly responsible to for any unpaid balance by your insurance. A service charge of 1 1/2% per month (18% per annual) on the unpaid balance will be assessed on all accounts exceeding thirty (30) *days* from the date of service Deductibles, co-payments, or non-insured patient payments are due upon date of service.

2. I understand that a **$50.00 no show/cancellation fee** may be applied to my account for a missed appointment or failure to give a 24 hour cancellation notice.

I understand **the following:** I agree that failure to make a payment will result in my account being sent to a collection agency. All payments must be then made to the collection agency. I agree to pay the collection agency fees of 33% of the balance along with my balance and other additional costs including attorney fees and court costs.

_____ _____

Patient or Guardian Signature Date

**Please give a name(s) of a person(s) that has your permission to talk to us about your account, or appointments on your behalf if needed. **

#1_____ #2 _____