DENTAL studio

Dentistry for kids and adults.

Patient Name _____MI _____Last Name _____

Date of Birth_____ Email _____

Parent name if minor: _____

Address_____

City _____State _____Zip Code_____

Home/Cell Phone_____

Referred by: Online Friend/Family Social Media Web Flyer Other:_____

Medical & Dental History

Are you currently under a physician's care? Yes No
If yes, please explain in detail:_____

_____

Physician's Name_____ Phone Number_____
Has a Physician or Dentist ever recommended you to take antibiotics before dental treatment? Yes No
Have you ever had or do you currently have the following conditions?

	Yes	No		Yes	No
Bleeding Problems	___	___	High Blood Pressure	___	___
Heart Murmur	___	___	Stroke	___	___
Breathing Problems	___	___	HIV/AIDS	___	___
Cancer	___	___	Joint Replacement	___	___
Diabetes	___	___	Organ Transplant	___	___
Heart Disease	___	___	Snoring/Sleep Apnea	___	___
Hepatitis	___	___	Blood Thinners	___	___

List all current Medications _____
Are you allergic or have you had a bad reaction to any of the following?
LATEX ANTIBIOTICS OTHER DRUGS

Female Patients

Are you pregnant? Yes No **Trimester** 1st 2nd 3rd **Are you nursing** Yes No

Name of OB/GYN _____ Phone _____

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How can we help you today? _____
When was your last dental visit? _____
Have you ever had unpleasant dental experience? Yes __ No __ If yes, please explain.
We want to make sure it does not happen again._____
_____

How is your dental health? Good __ Average __ Needs Improvement __ Unsure __
Do your gums bleed when you brush of floss? Yes __ No __ Sometimes __
Are you interested in cosmetic options? If yes, please explain. _____
_____

In accordance with HIPAA, I understand that I am giving my full permission to this office to use and disclose my protected health information in order to carry out treatment, payment activities and healthcare operations. I understand I have the right to revoke permission. I understand that my insurance company will send payment directly to the office unless prior arrangements have been made. **Initials** ____

I wish to assign benefits to Dental Studio and understand that I am responsible for any co-pay and deductibles that my insurance does not cover. Care Credit, Cash and all major Credit Cards are accepted for payment of services. Please remember that your insurance policy is a contract between you and your insurance company. Our staff makes a point to call ahead and get each patient's benefits and eligibility; however, it is the patient's responsibility to know how their benefits work. Prior to your appointment, it is suggested you contact your insurance company to verify coverage, your co-pay, deductible, co-insurance met to date and restrictions your insurance company may have. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination on your eligibility and benefits. **Initials** ____

I attest that all information I have provided on these two forms is accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Print Name: _____

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