Patient Information

Patient Name _____ **Date of Birth**_____ **Soc. Sec.#**_____

Address_____ **City**_____ **State**_____ **Zip**_____

E-mail_____ **Sex: M / F**

(circle one)
Minor Married Widowed Single Separated Divorced Partnered

Who Referred you to our office?_____

Phone Numbers

Home ( )_____ **Cell Phone( )**_____ **Work( )**_____ **Ext**_____

Spouses' work ( )_____ **Best time to reach you?**_____

IN CASE OF EMERGENCY CONTACT (SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD.)

Name _____ **Relationship**_____

Work # ( )_____ **Cell#( )**_____

Who is responsible for this account?_____ **Relationship to Patient**_____

Phone ( )_____

DENTAL INSURANCE INFORMATION

Subscriber_____ **Date of Birth**_____ **Soc. Sec.**_____

Employer_____ **Relationship to Pt**_____

Insurance Company full Name_____ **Group ID#**_____

Patient ID #_____

ASSIGNMENT AND RELEASE

William J Fessler Family Dentistry requires payment at time of service. If you choose to discontinue care before treatment is complete, you will only be charged for care received and any lab fees incurred. We submit to insurance as a courtesy. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, coinsurance, or any other balance not paid by your insurance at time of service. If our office is unable to collect payment from your carrier due to Insufficient subscriber information, or denial of benefits, the patient is responsible for balance on account. The patient and or responsible party agree to pay INTEREST at a rate of 1 ½% per month and all costs of collection, including reasonable attorney fees, on all amounts due on account more than 30 days from the date of service. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I further hereby assign all dental benefits, to which I am entitled, including private insurance, and other health plans to William Fessler Family Dentistry. Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I further give permission to pull a credit report as needed, should my account be turned over to an outside source for a collection effort. A fee of $65 is charged for patients who miss or cancel an appointment without 24 hours (business hours) notice. Current Bank fees for NSF checks will be billed to the patient for any returned checks.

_____ _____

(Responsible Party Signature: Patient, Guard ian or Parent) **(Date)**

HEALTH HISTORY

Physicians Name_____ **Date of last visit**_____

(Circle *Yes* or *No* to indicate if you have had any of the following)

Are taking Blood Thinners Yes No (if yes list)_____

Do you need to Pre-medicate Yes No (if yes reason)_____ **(list antibiotic)**_____

Have you taken Bisphosphonates (ie: for Osteoporosis) Yes No

AIDS/HIV	**Yes No**	**Epilepsy**	**Yes No**	**Radiation Treatment**	**Yes No**
Anemia	**Yes No**	**Fainting of Dizziness**	**Yes No**	**Respiratory Disease**	**Yes No**
Arthritis Rheumatism	**Yes No**	**Glaucoma**	**Yes No**	**Rheumatic Fever**	**Yes No**
Artificial Heart Valves	**Yes No**	**Headaches**	**Yes No**	**Scarlet Fever**	**Yes No**
Artificial Joints	**Yes No**	**Heart Murmur**	**Yes No**	**Shortness of Breath**	**Yes No**
Asthma	**Yes No**	**Heart Problems**	**Yes No**	**Sinus Trouble**	**Yes No**
Back Problems	**Yes No**	**Hepatitis Type____**	**Yes No**	**Skin Rash**	**Yes No**
Excessive bleeding	**Yes No**	**Herpes**	**Yes No**	**Special Diet**	**Yes No**
Sudden weight loss	**Yes No**	**High Blood Pressure**	**Yes No**	**Stroke**	**Yes No**
Blood Disease	**Yes No**	**Jaundice**	**Yes No**	**Swollen Feet or Ankles**	**Yes No**
Cancer	**Yes No**	**Jaw Pain**	**Yes No**	**Swollen Neck Glands**	**Yes No**
Chemical Dependency	**Yes No**	**Kidney Disease**	**Yes No**	**Thyroid Problems**	**Yes No**
Chemotherapy	**Yes No**	**Liver Disease**	**Yes No**	**Tonsillitis**	**Yes No**
Circulatory Problems	**Yes No**	**Low Blood Pressure**	**Yes No**	**Tuberculosis**	**Yes No**
Congenital Heart Lesions	**Yes No**	**Mitral Valve Prolapsed**	**Yes No**	**Tumor/growth on head**	**Yes No**
Cough that's chronic	**Yes No**	**Pacemaker**	**Yes No**	**Ulcer**	**Yes No**
Diabetes	**Yes No**	**Psychiatric Care**	**Yes No**	**Venereal Disease**	**Yes No**
Emphysema	**Yes No**				

Do you wear contact lenses? Yes No

Other conditions or if you answered Yes to above explain:_____

_____

(Women)

Are you pregnant? Yes No **Due Date**_____ **Nursing Yes no**

Taking Birth Control? Yes No

Medications

(List any medications and correlating diagnosis)

_____

_____

_____

_____

_____

_____

Allergies

(Circle all that apply)

Aspirin **Local Anesthetic**
Barbiturates **Penicillin**
Codeine **Sulfa**
Iodine **Other** _____
Latex _____
No Known Allergies

DENTAL HISTORY

Reason for today's visit:

_____

_____

Previous dentist:

_____

Address:

_____

_____

		Chew one side of mouth	**Yes No**	**Mouth Breathing**	**Yes No**
		Smoke Cigarette,pipe,cigars	**Yes No**	**Mouth Pain, brushing**	**Yes No**
		Clicking or popping jaw	**Yes No**	**Orthodontic treatment**	**Yes No**
		Dry Mouth	**Yes No**	**Pain around ear**	**Yes No**
		Fingernail Biting	**Yes No**	**Periodontal Treatment**	**Yes No**
		Food trapped between teeth	**Yes No**	**Sensitivity to**	**HOT COLD**
		Sensitivity to sweets	**Yes No**	**Sensitivity biting**	**Yes No**
		Grinding teeth	**Yes No**	**Sores/Growths in mouth**	**Yes No**
Bad Breath	**Yes No**	**Gums swollen tender**	**Yes No**	**Jaw Pain**	**Yes No**
Bleeding Gums	**Yes No**	**Blisters on lips gums**	**Yes No**	**Lip/cheek biting**	**Yes No**
Burning sensation on tongue	**Yes No**	**Loose teeth**	**Yes No**	**Broken filings**	**Yes No**

How often do you floss?_____

How often do you brush?_____