

Pacific Dental Care

Patient Information Sheet

Date _____

Patient Information

Patient's Name _____ Spouse's Name _____
 Responsible party if child: Name _____ Mother _____ Father _____ Legal Guardian _____
 If student, age 18 or older, name and address of school _____

Home address _____
 Home telephone _____ Work Telephone _____ Cell Phone _____
 Patients Birth Date ____/____/____ Male Female Single Married Widow Divorced Separated
 How did you find out about this office?: _____ Email _____

Employment Information

Responsible Party's Name _____ Birth Date ____/____/____
 Employer _____ Position _____ How long? _____
 Employer's address _____
 Spouses Name _____ Birth date ____/____/____
 Spouses Employer _____ Position _____ How long? _____
 Employers address _____

Credit Information

Financial References (to be completed if account is to be credit. Not needed if account is to be cash.)

Bank name and branch _____ Account Number _____
 Credit Card Type _____ Account Number _____
 Driver's License State and Number _____ Social Security Number _____
 Name of relative not living with you _____ Relationship to you _____
 Address _____ Telephone Number _____

Dental/Medical

1st Dental Insurance insurance policies are contracts between you and the insurance company. To avoid misunderstandings regarding dental insurance, our professional services are charged directly to you and you are personally responsible for payment of fees.

insured name		birth date		Social Security number	
street address		city		State	
zip	Relationship to insured		group/policy number		union number
employer					
insurance company (1)	address		city	state	zip

2nd Dental insurance complete second section only if covered by 2 insurance companies

insured name		birth date		Social Security number	
street address		city		State	
zip	Relationship to insured		group/policy number		union number
employer					
insurance company (1)	address		city	state	zip

Medical insurance

insured name		birth date		Social Security number	
street address		city		State	
zip	Relationship to insured		group/policy number		union number
employer					
insurance company (1)	address		city	state	zip

Patients Health History

Medical History

Do you have a personal physician? Y N
 Are you currently under a physicians care? Y N

Physicians Name _____
 Phone #: _____ Date of last visit _____
 Reason for last physician visit: _____

YOUR CURRENT PHYSICAL HEALTH IS:

Good Fair Poor

Do you smoke tobacco in any form? Y N

Do you have any implants, valves, rods, or pins? Y N

Are you taking any medications?

Please list _____

Have you ever taken Phen-Fen/Redux/Pondimin? Y N
 If yes, when? _____

For Women Only:

are you taking birth control pills? Y N

Are you pregnant? Due Date _____ Y N

Are you nursing? Y N

Have you ever had any of the following diseases or medical problems?

- | | |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes/Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ /ARC/AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Joints/Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalization for any reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Migraine Headaches (#/mo.) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse W/ regurgitation |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Therapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Therapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting/Dizzy Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches/Migraine | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Trait/ Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis A, B C, D | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |

Please list any other serious medical conditions that you had which are not listed above: _____

Are you allergic to any of the following?: (please circle all that apply)

- | | | |
|--------------------|-------------|--------------|
| Asprin | Erthromycin | Metals |
| Codeine | Jewelry | Penicillin |
| Dental Anesthetics | Latex | Tetracycline |

Please list any other drugs/medications that you are allergic to: _____

Dental History

What is the primary reason for your visit to our practice today? _____

Are you currently in pain? Y N

Do you require antibiotics before dental treatment? Y N

Dentists Name: _____

Phone number: _____ date of last visit: _____

YOUR CURRENT DENTAL HEALTH IS:

Good Fair Poor

When was the last time you had a complete dental evaluation? _____

Have you had a bad experience in the dental office? Y N

Do you floss daily? Y N Do you brush daily? Y N

Have you ever been informed or treated for the following dental conditions:

- | | |
|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Gums | <input type="checkbox"/> Y <input type="checkbox"/> N Loose Teeth |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad Taste/Odor | <input type="checkbox"/> Y <input type="checkbox"/> N Oral Cancer/Biopsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores/Ulcers | <input type="checkbox"/> Y <input type="checkbox"/> N Osseous Surgery |
| <input type="checkbox"/> Y <input type="checkbox"/> N Deep Cleanings/Scalings | <input type="checkbox"/> Y <input type="checkbox"/> N TMJ/TMD Joint Pain |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gum/Periodontal Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Toothbrush Abrasion |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hot/Cold sensitivity | <input type="checkbox"/> Y <input type="checkbox"/> N Wisdom Teeth Extraction |

Would you like fresher breath? Y N

Would you be interested in whiter teeth? Y N

Are you happy with the way your smile looks? Y N

If not, what would you change? _____

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and adherence to the applicable HIPAA national standards. It is my responsibility to inform this office of any changes in my medical status. I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary for dental treatment to be rendered by the dental staff.

_____ date _____

Doctor's Comment/Notes:

I verbally reviewed the medical/dental information with the patient (parent named herein)

Doctors signature _____ Date _____

- Accounts Paid in full on the date of service will incur no interest.
- Finance charges in the amount of 1.50 percent monthly or 18 percent annually will be applied to accounts not paid in full by the 75th day after service is rendered. The finance charge is retroactive to date of service and includes portions not paid by insurance company.
- Accounts 91 days old will be sent to an outside collection agency for servicing.
- Broken appointments: There is a \$50-200 charge for appointments that are broken without a minimum of 24 hours notice to the office. A 24 hour notice allows patients on a waiting list to be called and idle time to be filled. I agree to pay this fee if I fail to properly notify the office in the event of a cancellation.

Patient (parent) initials _____

Yearly Patient Information Updates/ (please initial)

Date	Date	Date	Date
Patient/Parent	Patient/Parent	Patient/Parent	Patient/Parent
DDS	DDS	DDS	DDS