CHOICE ONE DENTAL

Today's Date ____________________

PATIENT'S INFORMATION
(PLEASE PRINT)

First Name & Middle Initial ______________________________
Last Name ______________________________
Street Address ______________________________ Apt. #______
City ______________________________ State__________
Zip Code ______________________________
Email Address ______________________________
Home Phone # ______________________________
Work Phone # ______________________________
Work Extension ______________________________
Soc Sec # ______________________________
Cell Phone or Pager # ______________________________
Date of Birth (MM/DD/YYYY) ____________________ Age______
Marital Status: Single Married
Sex: Male Female
Employer ______________________________
Occupation ______________________________
Employer Address ______________________________
____
Driver's License # ______________________________

Is the patient the SAME person as the policy holder? (circle Yes or No)
If "Yes" then skip the rest of this box.
If "No" what is the relationship of the patient to the policy holder? _________

GUARANTOR/POLICY HOLDER'S INFORMATION

(PLEASE PRINT)

First Name & Middle Initial ______________________________
Last Name ______________________________
Street Address ______________________________ Apt. #______
City ______________________________ State__________
Zip Code ______________________________
Email Address ______________________________
Home Phone # ______________________________
Work Phone # ______________________________
Work Extension ______________________________
Soc Sec # ______________________________
Cell Phone or Pager # ______________________________
Date of Birth (MM/DD/YYYY) ____________________ Age_______
Marital Status: Single Married
Sex: Male Female
Employer ______________________________
Occupation ______________________________
Employer Address ______________________________
____
Driver's License # ______________________________

INSURANCE INFORMATION:

Policy Holder's Name ______________________________
Primary Insurance Company ______________________________ Policy # ____________________
Policy Holder's Name ______________________________
Secondary Insurance Company ______________________________

IN CASE OF AN EMERGENCY, LIST YOUR NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU:

Name ______________________________Relationship ____________________
Address ______________________________Telephone # (______) ____________________

HOW WERE YOU REFERRED TO US?

Friend or Family Member (Name) ______________________________
Yellow Pages Book ____ / Internet ____ Flyer ____ Other (Please Specify) ______________________________

I, the undersigned (patient or legally responsible party) authorize treatment to be rendered and assume financial responsibility. At the time of service I will pay for any charges not covered by insurance. **I acknowledge that all insurance benefits are estimates and not a guarantee of coverage. Any balances not paid by the insurance company will be my responsibility**. I acknowledge that all non-current balances on accounts over sixty days will incur a service charge on the unpaid balance. Any additional cost incurred in collecting this account including court costs, agency fees and attorney fees will be added to the balance due, **a minimum of 25% of outstanding balance**.

I have been informed of Choice One Dental's privacy policy and understand that confidential patient information is never shared or distributed to any other person or organization without the patient's authorization. I do authorize release of any information relating to my insurance claims and the assignment of ail dental insurance benefits to Choice One Dental.

I am aware that a charge of **$50.00** will be made for **broken appointments if 24 hour notice is not given**.

If the patient is under 18, I have been informed that a parent or legal guardian must be present or have given their consent for treatment provided.

SIGNATURE of person responsible for payment of account.______________________________ Date____________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Is there anything you'd like to change about your smile? ____________
   ____
2. When did you last receive dental treatment? ______________________
   What type of treatment? ___________________________________
3. Previous Dentist ____
   City, State ____
4. Do you have dentures, partial denture, bridges or crowns?
   If yes, when were they made? ______________________ Y N
5. Date of last physical examination ______________________
6. Have you been hospitalized during the past three years? Y N
7. Have you had any serious illnesses in the past three years?
   If so, please explain ______________________________ Y N
8. Are you under a physician's care? Y N
   If yes, for what condition? __________________________
9. Have you ever worn braces? Y N
10. Have you ever had gum surgery? Y N
11. Have you ever had any difficulty with any dental work or Extractions? Y N
12. Have you had any surgical prostheses? Y N
    (Joint replacements or implants)

Do you have or have you had any of the following conditions or diseases?

CARDIOVASCULAR

13. Rheumatic Fever Y* N
14. Congenital Heart Defect Y* N
15. Angina or Heart Attack Y* N
16. Heart Murmurs Y* N
17. Congestive Heart Failure Y N
18. Heart Surgery or Pacemaker Y* N
19. (High) or (Low) Blood Pressure (Circle One) Y N
20. Stroke Y N

RESPIRATORY DISORDERS

21. Asthma or Bronchitis Y N
22. Emphysema Y N
23. Hay Fever or Sinusitis Y N

ENDOCRINE DISORDERS

24. Diabetes Y N
25. (Hyperthyroidism) or (Hypothyroidism) (circle one) Y N

BLOOD DISORDERS

26. Anemia Y N
27. Do you bleed excessively when cut? Y N

KIDNEY DISEASE

28. Have you have any kidney infections? Y N
29. Have you had any kidney surgery? Y N

INFECTIOUS DISEASES

30. Hepatitis Y N
31. Venereal Disease (Within the last 10 years) Y N
32. Tuberculosis Y N
33. HIV Positive Y N

*If you answer "Y" to any of the starred questions, current American Heart Association standards may require that you take antibiotics Immediately before each dental appointment. If you fail to do so, we will be required to reschedule your appointment unless we receive a written exemption from a physician.

MISCELLANEOUS DISEASES AND DISORDERS

34. Frequent Fainting Y N
35. Liver Disease Y N
36. Arthritis Y N
37. Ulcers Y N
38. Glaucoma Y N
39. Radiation Therapy for Cancer Y N
40. Epilepsy Y N
41. Cancer Y N
42. Do you smoke? Y N
43. Do you use any other form of tobacco? Y N

Are you currently taking any of the following drugs or medications?

44. Antibiotics Y N
45. Blood Thinners Y N
46. Steroids or Cortisone Y N
47. High Blood Pressure Medicine Y N
48. Tranquilizers Y N
49. Aspirin Y N

Please write down all of the prescribed medications you are currently taking: ____
____
____

Do you have an ALLERGY or reaction to any of the following?

50. Latex or Sulfur Y N
51. Local Anesthetics Y N
52. Penicillin Y N
53. Other Antibiotics Y N
54. Codeine Y N
55. Other Pain Medication Y N
56. Aspirin Y N
57. Barbiturates or Sedatives Y N
58. Other Medicines Y N
    If yes, what medicines? ______________________________

Do you have any medical problem not listed above? Y N

If yes please explain ______________________________________
____

WOMEN ONLY

59. Are you pregnant? Y N

If yes, when are you due? ___________________________________

____

PATIENT'S SIGNATURE **DATE**

(Parents must sign for their minor children)

PATIENT'S INITIALS FOR UPDATE **DATE**

(Parents must sign for their minor children)

______________________________ __________
______________________________ __________
______________________________ __________

____ ________________

DOCTOR'S SIGNATURE **DATE**

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my dental care provider ***Choice One Dental*** to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name:____

Name: ____

Name: ____

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me and my billing.

- ☐ Only the following records or types of health information: ____.

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of ________, 20___.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs:____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.

____
Print Name

____ ________________________
Signature Date