CHOICE ONE
DENTAL CARE

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 Care'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**