PATIENT INFORMATION

CONFIDENTIAL

DATE ____________

SS# ____________

(PLEASE PRINT)

NAME ____________ (FIRST / MI / LAST) BIRTHDATE ____________ HOME PHONE ____________

ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

E-MAIL ADDRESS ____________ WOULD YOU LIKE NOTICES SENT BY EMAIL? Y N CELL PHONE ____________

CHECK APPROPRIATE BOX: ❑ MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

EMPLOYER ____________ WORK PHONE ____________

NAME OF PERSON RESPONSIBLE/INSURED FOR ACCOUNT ____________ SS# ____________ D.O.B. ______

SPOUSE OR PARENT'S NAME ____________ EMPLOYER ____________ WORK PHONE ____________

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE ____________ CITY ____________ STATE ______

WHOM MAY WE THANK FOR REFERRING YOU? ____________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ____________ PHONE ____________

PRIMARY INSURANCE CO. ____________ SECONDARY ____________

PATIENT MEDICAL HISTORY

PHYSICIAN ____________ OFFICE PHONE ____________ DATE OF LAST EXAM ____________

	YES	NO
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑

If yes, what medication(s) are you taking? ____________

	YES	NO
4. Do you use tobacco?	❑	❑
5. Do you use alcohol?	❑	❑
6. Do you use cocaine or other drugs?	❑	❑

7. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
❑	❑	Local Anesthetics (eg. novocaine)	❑	❑	Barbiturates	❑	❑	Aspirin
❑	❑	Penicillin or other antibiotics	❑	❑	Sedatives	❑	❑	Other ______
❑	❑	Sulfa drugs	❑	❑	Iodine			______

8. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking birth control pills?	❑	❑

9. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded
❑	❑	Heart Attack	❑	❑	Heart Murmur	❑	❑	Stroke
❑	❑	Rheumatic Fever/MVP	❑	❑	Frequently Tired	❑	❑	Hay Fever / Allergies
❑	❑	Swollen Ankles	❑	❑	Anemia	❑	❑	Tuberculosis
❑	❑	Fainting / Seizures	❑	❑	Emphysema	❑	❑	Radiation Therapy
❑	❑	Asthma	❑	❑	Cancer	❑	❑	Glaucoma
❑	❑	Low Blood Pressure	❑	❑	Arthritis	❑	❑	Recent Weight Loss
❑	❑	Epilepsy / Convulsions	❑	❑	Joint Replacement or Implant	❑	❑	Liver Disease
❑	❑	Leukemia				❑	❑	Prescription Weight Loss Medication
❑	❑	Diabetes	❑	❑	Hepatitis / Jaundice			
❑	❑	Kidney Diseases	❑	❑	Sexually Transmitted Disease	❑	❑	Respiratory Problems
❑	❑	AIDS or HIV Infection				❑	❑	Osteoporosis
❑	❑	Thyroid Problem	❑	❑	Stomach Troubles/ Ulcers	❑	❑	Other ______
❑	❑	Heart Disease	❑	❑	Chest Pains/Angina			

COMMENTS

____

Signature of Dentist Date

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered correctly. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents at time of services.

Signature ____________ Date ____________

Cancellation Policy/No Show Policy & Scheduled Appointments

1. ***Cancellation/No Show Policy for Dentist Appointment***

   Boerne Dental Center understands that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment.

   If an appointment is not cancelled at least 48 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. ***Schedule Appointments***

   Boerne Dental Center understands that delays can happen, however we must try to keep the other patients and doctors on time.

   If a patient is 15 minutes past their schedule appointment time we will have to reschedule the appointment.

___________________________________ ___________________

Patient Patient/Guardian Signature Date

Credit Card Information

Credit Card Number ____

Exp Date _____________________ CVC __________________________