Integrity Care
DENTAL

Patient Information

Patient Name ______________________________ Today's Date ____________
Last First MI

Gender M F Family Status: Married Single Child

Birth Date: __________ Social Security Number ____________________

Address: ____
Street Apartment Number

____
City State Zip Code

Phone Home: ____________ Work: ____________ Mobile: ____________

Email: ____

If under 18 parent/guardians name ______________________ Relationship ____________

Emergency Contact (Who does not live with you) Name: ______________ Phone: ____________

Health History Information

Have you ever had any of the following? Please Yes or No.

Heath Issues:	Y	N
Hepatitis/Jaundice	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐
Hearing Problems	☐	☐
Severe Headaches	☐	☐
Fainting/Dizziness	☐	☐
Nervousness/Anxiety	☐	☐
Drug Abuse	☐	☐
Blood Transfusion	☐	☐
Anemia	☐	☐
Sickle Cell Disease	☐	☐
Prolonged Bleeding	☐	☐
Taking Aspirin Regularly	☐	☐
How Often ______		
Congestive Heart Failure	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
How long ago? ______		
Pacemaker	☐	☐
Heart Surgery	☐	☐
How long ago? ______		
Irregular Heartbeat	☐	☐
Are you taking any Medications? Please list:	☐	☐

	Y	N
Chest pains	☐	☐
How long ago? ______		
Heart Murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Emphysema	☐	☐
Rheumatic Fever	☐	☐
Any other Heart Disorders?	☐	☐
Kidney Disease	☐	☐
Tuberculosis	☐	☐
HIV/AIDS	☐	☐
Hypothyroid/Hyperthyroid	☐	☐
Arthritis	☐	☐
Ulcers	☐	☐
Liver Disease	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Sexually Transmitted Diseases	☐	☐
Taking Steroids	☐	☐
Cancer/Growths	☐	☐
Radiation Treatments	☐	☐
Tobacco	☐	☐

	Y	N
Previous Endocarditis	☐	☐
Cardiac Transplant	☐	☐
Congenital Heart Defects/Disease	☐	☐
Chemotherapy	☐	☐
Prosthetic Cardiac Valve	☐	☐
Joint Replacement	☐	☐
Date __________		
Osteoporosis	☐	☐
Taking Blood Thinners	☐	☐
Have you ever needed Pre-medication prior to dental treatment?	☐	☐
Allergies to:		
Narcotics	☐	☐
Aspirin	☐	☐
Local Anesthetic	☐	☐
Iodine	☐	☐
Latex	☐	☐
Preservatives (e.g. Sulfites)	☐	☐
Metal	☐	☐
Sulfa Drugs	☐	☐
Antibiotics (e.g. Penicillin)	☐	☐
Others: Please Explain	☐	☐
____________________		

(Include prescriptions, over-the-counter medications, dietary and herbal supplements) ____________________

____

____

____

- Physician's Name: ____________________ Phone: ____________
- Pharmacy: ____________________
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Do you use controlled substances? ☐ Yes ☐ No
  If yes, please explain: ____________________
- Do you have a persistent cough lasting longer than 3 weeks? ☐ Yes ☐ No
  If yes, please explain: ____________________

For Women:

- Are you pregnant or think you might be pregnant? ☐ Yes ☐ No
- Are you nursing? ☐ Yes ☐ No
- Are you taking oral contraceptives? ☐ Yes ☐ No

Missed Appointment Policy: We do our best to arrange customized appointment times to best fit your schedule and your dental needs. Because this time have been reserved especially for you and canceling, rescheduling or missing your appointment will affect many people, it is required that 24 hours notice be given to avoid a fee of $30. We realize that our schedules are ever changing and are happy to accommodate prior to the 24 hours. In this way it is our desire that you will receive prompt and timely dental care. ________ ________ ________ ________

initial here initial here initial here initial here

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____________________ Date: ____________

Signature (Parent or Guardian If under 18)

I have reviewed my health history information and notified the dental staff of any changes.

Date: ____________ Signature: ____________________

Date: ____________ Signature: ____________________

Date: ____________ Signature: ____________________

To be completed by office staff:

Date	Initial Blood Pressure	Taken By

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Online ☐ Dental Office
☐ Yellow Pages ☐ Sign ☐ I'm a Current Patient ☐ Other_______________

Name of person or office referring you to our practice: _______________

Responsible Party Information

(if other than patient - must be 18 years or older)

Name: _______________
☐ Male ☐ Female ☐ Married ☐ Single

Social Security #: _______________ Birth Date _______________

Relationship to Patient: _______________

Phone (Home): _______________ (Work): _______________ Ext: _______ Best time to call: _______________

Address: _______________ (Cell): _______________
Street Apartment

_______________ Email: _______________
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _______________Occupation _______________

Address: _______________
Street City State Zip Code Phone

Insurance Information

Primary

Name of Subscriber: _______________ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _______________ ID #: _______________ Group #: _______________

Subscriber's Address:_______________
Street City State Zip Code

Subscriber's Employer Name: _______________

Address: _______________
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_______________

Insurance Plan Name and Address: _______________

____

Secondary

Name of Subscriber: _______________ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _______________ ID #: _______________ Group #: _______________

Subscriber's Address:_______________
Street City State Zip Code

Subscriber's Employer Name: _______________

Address: _______________
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_______________

Insurance Plan Name and Address: _______________

____

Consent for Services

As a condition of your treatment by this office, payment must be received at the time services are rendered. The practice depends upon reimbursement from the patients for the costs incurred in their care. You may pay with cash, check, visa, master card, or you may apply for financing through Care Credit (OAC). Please ask the receptionist for an application. It only takes a few moments to telephone in the application for approval.

Patients who carry dental insurance: Please understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services rendered. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Your co-pay or patient portion is due at each visit. This is only an estimate based on information relating to your benefits. We cannot guarantee the exact amount your insurance will pay.

A service charge of 1 1/2 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of twelve months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee at the time said services are rendered. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

***I also realize that this dental office is in compliance with the HIPAA regulations that were implemented on April 14, 2003 and I understand that a copy of the law is available to me at any time upon my request. Please ask if you have any further questions regarding the HIPAA Law or the privacy of your account with us.

______________________________ Date: __________ Relationship to Patient:

Signature of Patient or Guardian (If under 18)