Peninsula Prosthodontics

PATIENT INFORMATION RECORD

NAME_____ DATE_____

DATE OF BIRTH_____ SEX__ HOME PH_____CELL PH_____

ADDRESS_____

CITY STATE ZIP

EMAIL_____

EMERGENCY CONTACT_____CONTACT #_____

EMPLOYER_____ WORK PH_____

DENTAL INS._____

PRIMARY SUBSCRIBER NAME SOCIAL SECURITY # DATE OF BIRTH

_____

INSURANCE CO. NAME GROUP # PHONE NUMBER

_____

INSURANCE CO. ADDRESS CITY STATE ZIP

SEC. DENTAL INS._____

SUBSCRIBER NAME SOCIAL SECURITY # DATE OF BIRTH

_____

INSURANCE CO. NAME GROUP # PHONE NUMBER

_____

INSURANCE CO. ADDRESS CITY STATE ZIP

REFERRED BY_____ FAMILYDENTIST_____

FEES & **PAYMENTS: ALL CHARGES ARE THE PATIENT'S RESPONSIBILITY.** For patients with dental insurance we are **NOT PREFERED PROVIDERS AND ARE CONSIDERED OUT OF NETWORK.**
We **DO NOT ACCEPT ANY INSURANCE** as a form of payment but we will work with your carrier to maximize your benefit and provide you the documentation you need to receive reimbursement for your treatment.
PAYMENT IS DUE AT THE TIME OF SERVICE. Please note we charge $50.00 for returned checks.

X_____

SIGNATURE OF PATIENT/GUARDIAN ***DATE***

NOTICE OF STATEMENT OF PRIVACY PRACTICES: I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this statement.

X_____

SIGNATURE OF PATIENT/GUARDIAN ***DATE***

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MEDICAL HISTORY

PLEASE LIST OR ATTACH MEDICATIONS (Name, strength & dosage):_____

_____

LIST ALL KNOWN ALLERGIES:

_____

_____

YES NO - Have you lost or gained more than 10 pounds in the past year?
YES NO - Do you smoke? How much? _____ per DAY or WEEK
YES NO - Daily alcohol intake _____

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT THE PRESENT:

YES NO Heart surgery, disease, attack
YES NO Chest pain
YES NO Congenital heart disease
YES NO Heart murmur
YES NO Mitral Valve prolapse
YES NO Artificial heart valve
YES NO Rheumatic fever or rheumatic heart disease
YES NO Heart pacemaker
YES NO High blood pressure
YES NO Arthritis, rheumatism
YES NO Cortisone medication
YES NO Swollen ankles
YES NO Stroke
YES NO Diet – special/restricted
YES NO Artificial joint
YES NO Kidney trouble
YES NO Ulcers
YES NO Diabetes
YES NO Thyroid problems
YES NO Glaucoma
YES NO Contact lenses
YES NO Emphysema
YES NO Chronic cough
YES NO Tuberculosis
YES NO Asthma
YES NO Osteoporosis
YES NO Herpes
YES NO Bisphosphonates meds (Fosamax or Zometa)

YES NO Hay fever
YES NO Latex sensitivity
YES NO Allergies or hives
YES NO Sinus trouble
YES NO Radiation therapy
YES NO Chemotherapy
YES NO Tumors
YES NO Hepatitis A infectious/Hepatitis B-serum/Hepatitis C
YES NO Venereal disease
YES NO AIDS
YES NO HIV positive
YES NO Cold sores/fever blisters
YES NO Blood transfusions
YES NO Hemophilia
YES NO Sickle cell disease
YES NO Anemia
YES NO Bruise easily
YES NO Prolonged bleeding after injury or surgery
YES NO Liver disease
YES NO Yellow jaundice
YES NO Neurological disorders
YES NO Epilepsy or seizures
YES NO Fainting/dizzy spells
YES NO Nervous/anxious
YES NO Psychiatric/psychological care

YES NO Do you have any disease, condition or problems that haven't been listed?

Please list: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to

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ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health and/or medication.

PATIENT/GUARDIAN SIGNATURE

_____***DATE***_____

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