

Information Form - Dependant Child

Patient Name:
Last First MI Preferred Name

Date of Birth:

Address:

City State Zip Code

Phone: Best time to call:
Home Work Ext Mobile

One of our confirmation methods is email. They are sent out 2 weeks then again 3 days prior to an appointment for your convenience. Please write your email address if you are interested in receiving these emails.

Who does the patient primarily live with:

- ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather
☐ Guardian/Other

Parent's Marital Status:

- ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Please indicate who will be bringing patient in for appointments. They are responsible for the account and appointments.

- ☐ Mother ☐ Father ☐ Guardian

Name of person, office, or other source referring you to our practice:

Please provide the following information:

☐ Mother ☐ Stepmother ☐ Guardian

Name:

Address:

City

State

Zip Code

Phone:

Home

Work

Ext

Mobile

Best time to call:

Preferred phone contact:

☐ Home ☐ Work ☐ Mobile

Please write Date of Birth, Driver's License #, and Social Security #:

Employer & occupation:

Please provide the following information:

☐ Father ☐ Stepfather ☐ Guardian/Other

Name:

Address:

City

State

Zip Code

Phone:

Home

Work

Ext

Mobile

Best time to call:

Preferred phone contact:

☐ Home ☐ Work ☐ Mobile

Please write Date of Birth, Driver's License #, and Social Security #:

Employer & occupation:

Primary Insurance Information

Primary Dental Insurance:

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Social Security Number of insured person listed above:

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Social Security Number of insured person listed above:

Financial Guidelines

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients are ultimately responsible for all fees incurred for dental services at time of service. This office will help prepare and send claims to the insurance carrier and assist in making collections from insurance companies. This dental office cannot guarantee what the insurance benefits will be; however, we will estimate patient's portion due at time of service.

I understand that any estimate of fees for dental services will be guaranteed for 6 months from date of presentation. However, if treatment should change, a revision will be made and a new guarantee of fees will begin at the new presentation.

Our policy requires payment in full for all services rendered at the time of appointment, unless other arrangements have been approved. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency, fees, interest charges and any other expenses incurred in collecting your account.

I authorize any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Parent or Guardian:

Relationship to Patient:

☐ Mother ☐ Father ☐ Guardian

Response Date:

Medical History Information:

Your Primary Care Physician's name, address, & phone number:

Approximately when was your last physical exam?

What is the reason for your dental visit today?

☐ Exam ☐ Emergency ☐ Consultation

If new patient, please list prior dentist's name, address, & phone number:

When was your last visit to the dentist and what was done?

When were your last x-rays?

If you have ever had any complications following dental treatment, please explain:

Do you require Pre-medication with antibiotics before dental treatment? (if yes, write reason below)

☐ Yes ☐ No ☐ Don't Know

Reason for Pre-medication:

Have you ever taken Phen-fen or Redux (weight loss medications)?

☐ Yes ☐ No

Have you ever taken Fosamax, Aredia or other Bisphosphonates medications?

☐ Yes ☐ No

Please mark the box to indicate if any of the following apply to you presently or past history:

- | | | |
|--|---|---|
| <input type="checkbox"/> Acid Reflux / GERD | <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Alzheimer's/Dementia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Drug/Food Allergy |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur / MVP |
| <input type="checkbox"/> Heart Valve Surgery | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV+ / AIDS | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Migraines/Headaches |
| <input type="checkbox"/> Muscular Disorder | <input type="checkbox"/> Neck/Back Pain | <input type="checkbox"/> Neurological Problem |
| <input type="checkbox"/> No Epinephrine | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pre-med Not Needed | <input type="checkbox"/> Premedication Needed |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Shunts/Stents Placed | <input type="checkbox"/> Sight Impaired |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Tuberculosis | |

Please list any other surgeries, drug/food allergies, or medical conditions you have or ever had that were not indicated above.

Please list any medications you are currently taking (prescription and non-prescription):

Dental History Information:

How frequently do you brush your teeth?

- ☐ 3 (+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss your teeth?

- ☐ 1 (+) a day ☐ 2 - 6 weekly ☐ 1 - 6 monthly ☐ Seldom ☐ Never

What type of toothbrush bristles do you use?

- ☐ Extra-Soft ☐ Soft ☐ Medium ☐ Hard

Please indicate if you have any of the following:

- ☐ Red, swollen or bleeding gums.
☐ Sensitive tooth, teeth or gums.
☐ Blisters/Sores in or around mouth.
☐ Bad breath.
☐ Lost/Broken filling(s).
☐ Broken/Chipped tooth.
☐ Grinding or clenching teeth.
☐ Ringing in ears.
☐ Discomfort, clicking, popping, locking in jaw joint.
☐ Currently have dental implants, partials, or dentures.

If any of the previous concerns are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize Dr. David Hergott and/or Dr. Sara Curcio to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to Hergott Dental Associates to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

You are entitled to a copy of our "Notice of Privacy Practices". Would you like a copy?

☐ Yes ☐ No

List any individuals you would allow us to release information to:

What type of information can be shared:

☐ Dental Diagnoses and Treatment ☐ Billing/Financial Information

Signature of Patient, Parent, or Guardian:

Relationship to Patient:

Response Date: