Geyer Dental

PATIENT INFORMATION:

Today's Date: _____

Patient Name: _____
LAST, FIRST M.I.

Date of Birth_____ Social Security #: _____

Gender: Male: □ Female: □

Address:_____

_____

CITY , STATE ZIP

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Emergency Name and #_____

Has any member of your family been treated in our office?: _____

DENTAL INSURANCE INFORMATION:
Primary Policy:

Name of Insured: _____ D.O.B:_____
LAST, FIRST M.I.
Employer:_____Insurance Co:_____

Social Security #: _____Group #:_____
ID#:_____Ins. Phone #: _____

Claims Address: _____

Secondary Insurance (if applicable):

Name of Insured: _____ D.O.B:_____
LAST, FIRST

Employer:_____Insurance Co:
_____

Group #:_____ID#:_____Ins. Phone #: _____

Social Security #: _____

DENTAL HISTORY:

Reason for today's visit?

Date of last dental visit?_____

Did you bring x-rays? □ YES □ NO

Is there anything in your mouth or about your smile that you would like to change or modify?

□
YES

□ NO

If yes, please specify:

How do you rate your dental health? □ Good □ Fair □Poor

BadDo your gums bleed when you brush or floss? □Yes □ No

Do you own an electric toothbrush? □ Yes □ No

Do you smoke or use chew tobacco? □ Yes □ No

Please check if you have or do any of the following:

□ Bad Breath
□ Blisters on Lips/Mouth
□ Clicking/Popping of Jaw
□ Clenching of Teeth
□ Grind Teeth
□Broken/Loose Teeth or Filling
□ Sensitivity to Biting
□ Sensitivity to Sweets
□ Sensitivity to Hot/Cold
□ Jaw Pain
□ Ear Pain
□ Headaches
□ Dry Mouth
□ Missing Teeth
□ Sores or Growths
□ Mouth Breathing
□ Suck Your Thumb
□ Food Collecting

Have you been treated for any of the following?

□ Orthodontics □ Periodontal Disease □Grinding

□ Do you experience dental anxiety? □ Yes □ No

Do you have any allergies or have you had any bad reactions to:

□ Local Anesthetic
□ Antibiotics _____
□ Latex
□ Other _____

MEDICAL HISTORY
Are you under physician's care? □ Yes □ No If yes, for what? _____

Physician's name: _____ Physician's #: _____
Please list medications and other pills you are taking:

Do you generally take antibiotics before a dental visit? □ Yes □ No

Please check any and all that you have had: (indicate date if possible)

□ Heart Disease	□ Diabetes	□ Cancer	□ Glaucoma
□ Shortness of Breath	□ Thyroid Problems	□ Radiation	□ Osteoporosis
□Pacemaker	□ Respiratory Problems	□ Shingles	□ Liver Disease
□ Rheumatic Fever	□ Psychiatric Issues	□ Chemotherapy	□ Hepatitis
□ Heart Murmurs	□ Nervous Disorders	□ Arthritis	□ Asthma
□ Blood Disorders	□ HIV/Aids	□ Epilepsy /Seizures	□ Sleep Apnea
□ Abnormal Blood Pressure	□ Kidney Disease	□ Major Surgery	
□ Fainting or Dizziness	□ Bleeding/Clotting	□ Artificial Joints	

Are there any other medical issues or conditions not listed that we should know about?

Females: Are you pregnant or trying to get pregnant? □ Yes □ No

Are you nursing? □ Yes □ No

Are you on birth control pills? □ Yes □ No

Please certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status.

Signature of patient or guardian:_____Date: _____

CONSENT FOR TREATMENT:

1. I hereby authorize Doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed necessary to make a thorough diagnosis of dental needs.
2. Upon such diagnosis, I authorize the Doctor and/or Hygienist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware that this office provides optimal care as recommended by the ADA and my dental insurance maynot cover certain procedures. It is my responsibility to be aware of what is covered by my insurance.
3. I agree to the use of anesthetics and other medications as necessary. I fully understand that the use ofsaid agents imposes certain risks and realize that it is necessary to inform the doctor and staff of any drugs, including recreational drugs that I may be taking in order to minimize these risks.

Patient or Guardian (Printed): _____

Signature of Patient or Guardian:_____Date: _____

FINANCIAL AND OTHER POLICIES:

I understand that payments for all services are to be paid at the time of service unless different payment arrangements are made in advance. We will work with you if we have confirmed dental insurance and collectonly the estimated copayment at the time of service. We make no guarantee that the amount we collect is accurate. We estimate the collected copayment from historical data. If you want a more accurate estimate, ask to have a pretreatment estimate to your insurance company. We will gladly submit your insurance claim to the insurance address you gave us. Once we reach your annual maximum benefit, we will look to you forcomplete payment at the time of service unless a different payment arrangement has been made. We accept cash, checks, money orders and all major credit cards for your payments.

In accordance with HIPAA, I agree to the disclosure of my protected health information to my insurancecompany. I authorize my insurance company to pay Geyer Dental Group directly.

I have read the above Financial and Other Policies and agree to the content. Signed:_____Date:_____