Patient Information

Patient Name: _____ Date: _____
Last, First MI

Social Security #: _____ Birth Date: _____ Gender ____

Address: _____
Street City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Driver's Lic. # _____ Email Address: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

*if yes to any of the starred conditions, please call prior to your appointment…premedication may be required.

- ☐ AIDS
- ☐ Allergies (Medicines)
- ☐ Allergies (Pollen/Dust)
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve*
- ☐ Artificial Joint*
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problem
- ☐ Bloody Sputum
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores
- ☐ Congential Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting
- ☐ Fever Blisters
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Cough
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack/Failure
- ☐ Heart Disease
- ☐ Heart Pace Maker*
- ☐ Heart Murmur*
- ☐ Heart Surgery
- ☐ Hepatitis B or C _____
- ☐ Hepatitis A (Infectious)
- ☐ Hemophilia/Bleeding Prob
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heart Beat
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse*
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Night Sweats
- ☐ Osteoporosis/Bone Disease
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Renal Dialysis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever*
- ☐ Rheumatism
- ☐ Recent Blood Transfusion
- ☐ Recent Weight Loss
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Shortness of Breath
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Tattoos
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Tumors or Growths
- ☐ Venereal Disease
- ☐ Ulcers
- ☐ Unexplained Fever
- ☐ X-Ray Treatments (Radiation)
- ☐ Other _____

• Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• Do you smoke or chew? ☐ Yes ☐ No Any sores or growths in your mouth? ☐ 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 Physician Name/Number _____
If yes, please explain: _____

• Are you allergic to any medications or substances? ☐ Yes ☐ No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

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 of patient, parent or guardian

Ed Tony Francisco D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ I could not communicate with the patient.
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient _____

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ 800 Dentist ☐ Insurance ☐ Other _____

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

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
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 Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

Person to Contact in Case of an Emergency

Name: _____

Address:_____

City/State/Zip: _____

Telephone #: _____

Relationship to Patient: _____

Consent for Services

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

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients 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.

A service charge of 1½% 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 six 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, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as 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 have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of guarantor of payment/responsible party

Broken Appointment Policy

When an appointment is made, that block of time is reserved for you. If you are unable to make that appointment, please be courteous to the other patients and our office staff, who have prepared for your visit, to notify us 24 hours in advance if unable to attend.

A charge will be assessed for broken appointments without 24-hour notice.

$60.00 – will be assessed for first broken appointment
$70.00 – will be assessed each broken appointment thereafter

_____ Date: _____

Signature of patient, parent or guardian