PATIENT INFORMATION FORM

This information is necessary for your health and our records and will be considered confidential

Name: _____ Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed
Last First Middle Initial Preferred Name

Address: _____ Gender_____
Street City State Zip

E-mail:_____ ◯ I would like to receive correspondences via e-mail/text

Birth date: _____ Telephone: Home _____ Work _____ Cell _____

Place of Employment (or school):_____ Social Security #: _____

Whom may we thank for referring you to our office? _____

Former dentist name / Telephone: _____ Date of last visit: _____

Emergency Contact Name: _____ Telephone: _____ Relationship: _____

FAMILY INFORMATION

(Parent of Minor)

Name: _____

Address: _____ Telephone: _____

Birth date: _____ Social Security #: _____

Employer: _____ Dental Insurance: _____

We are happy to assist you with processing your dental claims. However, you are responsible for your dental bill. Should we encounter unreasonable difficulty securing payment for our services, you must understand and fulfill your obligation to pay, regardless of the position of your insurer.

_____
Initials of person responsible for account

INSURANCE INFORMATION

Name of Insured: _____ Social Security #:_____ Birth date: _____

Dental Insurance Company: _____ Group #: _____

Name of Employer: _____

Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Secondary Insurance Information

Name of Insured: _____ Social Security #:_____ Birth date: _____

Dental Insurance Company: _____ Group #: _____

Name of Employer: _____

Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

METHOD OF PAYMENT

Please check one of the following:

_____Payment in full at each appointment / Upon receipt of statement

_____Financing

(Prior arrangements must be made. Must complete credit application.)

FINANCE CHARGE. If I do not pay the entire new balance within 90 days of the monthly billing date, a FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $134.00) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account. Collection fees can be a flat rate of 35% or more.

_____
Initials of person responsible for account

FINANCIAL AUTHORIZATIONS

I authorize my name to be used as a "signature on file" on any insurance claim and to release any information relating to that claim, and to authorize payment directly to Bob Koenitzer, DDS, Inc. I agree that, regardless of insurance coverage, I am responsible for payment for services rendered.

RESPONSIBLE PARTY

_____ _____
Print Name Date

_____ _____
Signature of Responsible Party State Drivers License Number

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Physician: _____ Telephone: _____ Kaiser #: _____

Are you under a physician's care now? ◯ Yes ◯ No Date of last visit: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

_____

_____

_____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No _____

Do you use controlled substances? ◯ Yes ◯ No _____

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____