SADDLEROCK DENTAL

NEW PATIENT INFORMATION

Patient Name _____ DOB _____ SS# _____

Mailing Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Alternate (cell) Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Subscriber Name _____

Subscriber DOB: ____/____/_____ Subscriber SS#: _____ Group #_____

Is there a Secondary Insurance we should be billing? _____ Policy # _____

HEALTH HISTORY

PRIMARY MEDICAL PROVIDER _____ Phone # _____

1. Do you have any current medical conditions? NO _____ YES _____

   If yes, please list: _____

2. Are you currently under a physicians care? NO _____ YES _____

   If yes, please explain: _____

3. Have you been hospitalized for any reason in the last 5 years? NO _____ YES _____

   If yes, please explain: _____

4. What medications are you currently taking? _____

   _____

   Have you ever taken FenPhen, Redux, Aredia, Relast, Zometa, Fosamax, Actonel, Boniva, or Didronil?

   NO _____ YES _____

   Have you ever or do you need to PRE-MEDICATE prior to your dental treatment? NO _____ YES _____

5. Do you use cigarettes, cigars, pipes or chewing tobacco? NO _____ YES _____
6. Are you pregnant or nursing? NO _____ YES _____
7. Are you allergic to or have you reacted adversely to ANY of the following medications? (circle)

   ASPIRIN LOCAL ANESTHETIC LATEX PENICILLIN SULFA CLINDAMYCIN PAIN PILLS

   Other: _____

HEALTH HISTORY CONTINUED

Please **CIRCLE** if you have had or currently have any of the following medical conditions:

AIDS/HIV	DIABETES	NERVOUS PROBLEMS
ALCOHOL ABUSE	COLITIS	VENEREAL DISEASE
ANAPHYLAXIS	DIFFICULTY BREATHING	OSTEOPOROSIS
ANEMIA	EMPHYSEMA	PACEMAKER
ARTHRITIS	EPILEPSY	HEART SURGERY
ARTIFICIAL JOINTS	FAINTING	PSYCHIATRIC CARE
ARTIFICIAL HEART VALVE	FOOD ALLERGIES	RADIATION TREATMENT
ASTHMA	HEADACHES	RHEUMATIC FEVER
BACK PROBLEMS	HEART MURMUR	SCARLET FEVER
EXCESSIVE BLEEDING	HEART PROBLEMS	SPINA BIFIDA
BLOOD TRANSFUSION	HEMOPHILIA	STROKE
CANCER	HEPATITIS	SURGICAL IMPLANT
CIRCULATORY PROBLEMS	HIGH BLOOD PRESSURE	THYROID PROBLEMS
CORTISONE TREATMENT	LIVER DISEASE	TUBERCULOSIS
ULCERS	MITRAL VALVE PROLAPSE	DRUG DEPENDENCY
COLD SORES	GUM DISEASE	OTHER

If Other, please specify: _____

Have you used nitrous oxide (laughing gas) in the past? Yes No

Do you think you will need it in the future? Yes No

I understand that even routine dental care can have risks such as adverse reaction to anesthetic or unforeseen complications requiring additional cost and care, and I accept such risks. I further certify that medical information I entered on this sheet is correct to the best of my knowledge and that I may ask for and receive answers to further questions regarding care prior to any treatment.

_____

Signature of Patient/Parent/Guardian Date

Authorization, Release and Agreement to Pay for Services Rendered

I authorize the dentists to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full is expected at each appointment. If you have any questions concerning financial arrangements, or need special arrangements, please ask for assistance.

_____Cash _____Personal Check _____Credit Card

Late Charges

If I do not pay the entire balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is repayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on the amount or any future outstanding balances.

Signature of Patient (or Parent if minor) _____ Date:_____

We reserve the right to charge for appointments cancelled or broken without 24 Hours notice.