PETTY DENTAL

Patient's LAST NAME, FIRST NAME, MIDDLE NAME: _____

Name you would like to be called:_____

ADDRESS, CITY, ST, ZIP:_____

Your HOME phone_____Your WORK #_____EXT ____ Your CELL # _____

Your GENDER: M___, F___ Your MARITAL Status: Single___, Married___, Divorced___, Widowed___

Your Social Security Number_____-_____-_____ Your BIRTHDATE_____/_____/_____

Your EMPLOYER_____ Occupation or position_____

Your e-mail_____ If a student, school attending_____

How did you hear about our office? Who may we thank for their recommendation?

Family_____ Friend/Coworker_____

Google reviews____ Facebook_____ Website_____ Building/Sign_____ Other _____

IF APPLICABLE: SPOUSE'S NAME_____

Their WORK # _____ CELL #_____

EMPLOYER_____Occupation or position_____

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PERSON RESPONSIBLE FOR PAYMENT(Parent or Guardian signing below):_____

(if different from above) ADDRESS CITY, ST, ZIP_____

Their Home #:_____ WORK # _____ CELL #_____

Their Social Security Number_____-_____-_____ Their BIRTHDATE_____/_____/_____

Their Gender: M___F___ Their MARITAL Status: Single____, Married____, Divorced____, Widowed____

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AUTHORIZATION OF CARE AND PAYMENT FOR THIS PATIENT

- **I consent to treatment needed or desired for the above named patient. This may include, but is not limited to: Medications, Dental procedures, X-rays, Photographs and/or other studies performed by Dr. Petty, his hygienists, or assistants.**
- **I acknowledge full responsibility for payment of all charges for dental services, materials and/or lab fees. I agree to pay my portion AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE with the Treatment Coordinator. I understand that any account considered delinquent may be subject to billing charges, collection costs and/or attorney's fees.**

SIGNATURE:_____DATE:_____

PARENT or GUARDIAN SIGNATURE_____DATE:_____

ACKNOWLEDGMENT: I have seen or received a copy of this office's Notice of Privacy Practices.

Patient Name (print) _____ Relationship to patient_____

Signature_____ Date _____

* You May Refuse to Sign This Acknowledgment*

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FOR OFFICE USE ONLY: Employee completing this section: _____

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 ____ Communication barriers prohibited obtaining the acknowledgement _____ An emergency situation prevented us from obtaining acknowledgement _____Other (please specify)_____

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THE REMAINDER OF THIS FORM IS <u>ONLY IF</u> YOU HAVE <u>DENTAL INSURANCE</u>:

Legal name of EMPLOYEE/Subscriber who has the insurance_____ _____

Relation to patient_____ Is their Address & Phone the same as reverse? ____YES

If NO, their Address, City, ST, ZIP _____

Who is the EMPLOYER that provides the insurance? _____

Please provide group numbers or ID numbers **only if you do not have an insurance card we can make a copy of**

_____

Their Home Phone: (_____)_____ Work # (_____)_____ Cell #: (_____)_____

Their Social Security #: _____-_____-_____ Their Date of Birth_____/_____/_____

Their Gender: ___M __ F Their MARITAL Status: ___Single ___Married ___Divorced ___Widowed

Please remember: Dental insurance is a benefit to employees to help cover dental expenses. As a professional courtesy to our patients, our staff will file for your insurance payment. We wait 4 to 8 weeks to receive payment for the services you have already received. **<u>You are responsible for the total fee regardless of what your plan does or does not pay.</u>**

Our policy is that **you pay your deductible and your estimated co-pay the day you receive treatment.** We make every effort to provide our patients with the best estimate of insurance coverage based on your employer's contract. Due to the rising costs and time consumed in insurance filing, billing and collections, please do not ask us to "bill the insurance first, then send me a statement."

If, after the insurance benefit is received, there is a portion remaining we will send you a statement for the difference. We ask that you make your payment promptly as we have already waited 4 to 8 weeks to receive your benefit check.

PLEASE READ AND SIGN:

To the extent permitted by applicable law, I authorize release to my dental insurance carrier any information and documentation relating to claims for payment and/or any request for any pre-treatment estimate without any further authorization in the future.

I AUTHORIZE PAYMENT DIRECTLY TO DR. JOHN E. PETTY / PETTY DENTAL FROM MY INSURANCE COMPANY.

Signature: _____ **DATE:** _____

PERSON COMPLETING THIS FORM, IF OTHER THAN PATIENT: _____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Joint
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Cancer Radiation Therapy
☐	☐	Cancer- Chemotherapy
☐	☐	Chest Pain
☐	☐	Cholesteroll
☐	☐	Colitis/Irritable Bowel
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells

Y	N	Conditions
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Trouble
☐	☐	Hemophilia
☐	☐	Hepatitis A, B Or C
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Lung Disease
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Pain In Jaw Joints
☐	☐	Prolonged Bleeding
☐	☐	Psychiatric Problems
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Diseases
☐	☐	Shingles

Y	N	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)