Medical Alert
☐ Yes ☐ No

STEINHOF DENTAL

PATIENT INFORMATION

Patient Name: _____
Last Name First Name Middle Initial

Social Security #: _____ **Date of Birth:** _____

Gender: ☐ M ☐ F **Maritial Status:** _____

Address: _____

_____
City State Zip

Email: _____

Phone: _____ _____ _____
Home Cell Work

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy City/State: _____

Pharmacy Number: _____

EMPLOYMENT INFORMATION

Employer: _____

City/State: _____

Occupation: _____

DENTAL HISTORY

Place a mark on "yes" or "no" to indicate if you have or have had any of the following:

Reason for Visit: _____

_____

Former Dentist: _____

City/State: _____

Date of Last Visit: _____

Date of Last Dental Xrays: _____

Bad Breath	☐ Yes	☐ No	Broken Fillings	☐ Yes	☐ No	Pain around Ear	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	Clicking or Popping Jaw	☐ Yes	☐ No	Periodontal Treatment	☐ Yes	☐ No
Blisters	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No	Sensitivilty	☐ Yes	☐ No
			Food Collection in Teeth	☐ Yes	☐ No	Sores/Growths in Mouth	☐ Yes	☐ No
			Grinding Teeth	☐ Yes	☐ No	OTHER (Please explain Below):	☐ Yes	☐ No
			Gums Swollen/Tender	☐ Yes	☐ No			
			Loose Teeth	☐ Yes	☐ No			
			Mouth Pain, Brushing	☐ Yes	☐ No	How often do you floss?		
			Orthodontic Treatment	☐ Yes	☐ No	How often do you brush?		

HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have or have had any of the following:

Addiction	☐ Yes	☐ No	Growths / Tumors	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Respitartory Problems	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Stomach Problems	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
			If on Medication, Name?			Ulcer	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Chemotherapy/Radiation	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	OTHER (Please explain Below):	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No			
Epilepsy	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Fainting or Dizziness	☐ Yes	☐ No	Nervous Disorders	☐ Yes	☐ No			
Glaucoma	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			

Do you have any artificial joints, heart valves, stents, pins/rods or other prosthetics implanted in your body? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had any complications following Dental Treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to the hospital or needed Emergenct care in the last two years?

If yes, please explain: _____

Women:

Are you Pregnant? ☐ Yes ☐ No Due Date: _____ Are you Nursing? ☐ Yes ☐ No

Please Flip Over to Complete ⟶

RESPONSIBLE PARTY INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Plan Name: _____

Insurance Address: _____
Street City State Zip

Name of Insured: _____ **Is Insured a patient?** ☐ Yes ☐ No
Last Name First Name Middle Initial

Insured's Date of Birth: _____ **ID Number:** _____ **Group Number:** _____

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Other _____

SECONDARY INSURANCE

Insurance Plan Name: _____

Insurance Address: _____
Street City State Zip

Name of Insured: _____ **Is Insured a patient?** ☐ Yes ☐ No
Last Name First Name Middle Initial

Insured's Date of Birth: _____ **ID Number:** _____ **Group Number:** _____

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Other _____

REFERRAL INFORMATION

Whom may we Thank You for Referring you to our Practice?

☐ Another Patient, Friend ☐ Online ☐ School ☐ Dental Office ☐ Work

☐ Another Patient, Relative Name of Person or Office Referring you to our Practice: _____

CONSENT FOR SERVICES AND BILLING

As a condition of your treatment by Steinhof Dental Clinic, 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 prior to 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) 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

_____ Relationship tp Patient: _____
Printed Name of Patient, Parent or Guardian