PATIENT INFORMATION

Today's Date: ______________________________

Patient's Name: ____

Last Name First Name Middle Initial Nickname :)

Patient's SS#: ________ - _______ - _________Birth Date: _____/____/___________ Sex: □ M □ F Age:___________

Married Single Divorced Minor Other_____________ Email: ____

Address: ____ Home: (___) ________________________

City: _______________________________State: ________ Zip: _____________ Cell: (___) _____________________________

Employer___________________________Occupation____________________Work: (____)____________________EXT_____

Preferred method of communication:(please circle) HOME CELL EMAIL WORK

Emergency Contact: ____ Phone#(____)_____________________________

INSURANCE INFORMATION

Primary
Policy Holder: ____ DOB____/____/_____Policy Holder's SS#: ____-____-______

Last Name First Name

Employer:____ Relationship to Patient:___________________________

Insurance Co._____________________________ID#: ______________________________Grp#__________________________

Secondary
Policy Holder: ____ DOB____/____/_____Policy Holder's SS#: ____-____-______

Last Name First Name

Employer:____ Relationship to Patient:___________________________

Insurance Co._____________________________ID#: ______________________________Grp#__________________________

REFERRAL INFORMATION:

Whom may we thank for referring you to our office: ____

ACKNOWLEDGEMENT:

My signature below certifies that the information provided on this form is accurate and completed by the patient or their guardian

Patient/Guarding Signature:____

Guardian Printed Name:____

Guardian Relationship to Patient:____

THANK YOU :)

MEDICAL HISTORY

Do you need to be pre-medicated for your dental appointments? YES NO

If yes, please provide reason: ____

Please provide name of medicine:______________________________

Please circle to indicate if you have or have had any of the following:

AIDS/HIV	Anemia	Arthritis	Artificial
Artificial Joints	Asthma	Back Problems	Blood Disease
Cancer-Chemotherapy	Congenital Heart Defect	Cortisone Treatments	Diabetes
Emphysema	Epilepsy	Fainting Spells	Glaucoma
Headaches	Heart Murmur	Heart Problems/Surgery	Heart Valves
Hepatitis Type _____	Herpes	High Blood Pressure	Kidney Disease
Liver Disease	Low Blood Pressure	Mitral Valve Prolapse	Nervous Problems
Pace Maker	Psychiatric Care	Radiation Therapy	Rheumatic Fever
Scarlet Fever	Seizures	Shortness of Breath	Sinus Trouble
Stroke	Thyroid Problems	Tuberculosis	Ulcers
Venereal Disease	Yellow Jaundice	Tobacco User	

Have you ever been hospitalized in the past five years? YES NO

If yes, please provide reason for hospitilzation:____

Are you currently under the care of a Physician? YES NO

If yes, please provide reason:____

Women only, please circle:

I am pregnant:) YES NO Due Date:__________________

I am nursing? YES NO

I am taking birth control pills YES NO

ALLERGIES:

Aspirin ☐	Local Anesthetic ☐	Penicillin	Sulfa ☐
Iodine ☐	Latex	Metals ☐	Codeine
Tetracycline	Erythromycin		

List any allergies not mentioned: ______________________________

MEDICATIONS:

List any medication you are currently taking and the correlating diagnosis:

____

____

Primary Physician______________________ Primary Physician Phone# (____)______________

Pharmacy Name______________________ Pharmacy Phone#(____)______________

Please circle to indicate if you have or have had any of the following:

Abnormal bleeding after tooth extraction or oral surgery

Bad breathe | Bleeding Gums | Blisters on lips or mouth

Burning sensation on tongue | Chew on one side of mouth | Dry mouth

Clicking or popping jaw | Grinding teeth | Gums swollen/tender

Jaw pain | Loose teeth or broken fillings | Mouth breathing

Sensitivity to hot/cold | Sensitivity when biting | Sensitivity to sweets

****

Privacy Practices Statement: Acknowledgement of Receipt

By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Statement from this office. I have read the Privacy Statement and any questions I had have been answered by the office staff. Please ask one of our teammates to provide you with a copy.

Today's Date:____

Patient Printed Name:____

Patient/Guardian Signature:____

Guardian Printed Name:____

Guardian Relationship to Patient:____

In order to provide the upmost security to you, we are not allowed to disclosed any information regarding your care to anyone. Your Dental Insurance Company, your Primary Physician and Specialist whom we refer you to, are the only ones exempt from the HIPAA Law. All others need to be authorized by the patient.

Please provide that information below.

Person authorized to obtain my records:

Printed Name:____

Contact Number:____

Relationship to Patient:____

****

Welcome to Parkway Smiles Dentistry!

Our goal is to provide excellent service and quality of care for you so that you can regain and maintain your health quickly, and efficiently. We also have a personal, professional and ethical responsibility to care for your oral health to the best of our ability. It is our greatest aspiration to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office. Referrals are the best compliments after all. We welcome you to our office and look forward to a long and healthy relationship. We thank you for allowing us the opportunity.

Our office policies help us achieve our goal. Please read, initial and sign.

__________**Concerns:** It is our policy to ensure complete satisfaction of all of our patients with the service and care they receive at our office. If you feel that we have not met our policy, please see our Office Manager, with any concerns you may have to resolve them immediately. *We will do everything in our power to make things right by you.*

__________**Emergencies:** It is our goal to eliminate all potential dental emergencies by providing care for you before they become a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. Please call us right away and we will provide you with the next available appointment. We do set aside time each day for emergencies.

__________**Treatment recommendations** are based on your health not on your insurance or lack thereof**.** If you have insurance, it is your responsibility to be aware of your benefits. Remember*, insurance companies are not concerned about your health or well being.*

__________**Assignment of benefits:** I confirm that I have dental insurance with the Insurance Company(ies) provided and I authorize and consent that Dr. Su-En Thlick and Associates of Parkway Smiles Dentistry use the information I have provided and disclose such information to the Insurance Company(ies) I provided by me for the purpose of obtaining payment for services. I authorize the use of my signature on all insurance submissions

__________If you **miss a reserved appointment**, it compromises your health. It is important to make it up. It is critical to your health to do so in order to avoid setbacks in your care and maintenance of your teeth and gums. If you cannot keep your reserved appointment (*except in the case of an emergency*) you are expected to call our office within *48 business hours* of your reserved appointment to update our team. *Saturdays and Sundays are not considered business days*. There is a $50.00 fee, for all no-shows, per hour. *This fee is not covered by insurance and is non-refundable.*

__________We run a **zero balance office**. In order to reserve appointment times with the doctors, *we expect payment in full prior to the time treatment is provided.* We have several financial options available for all of our patients.

By signing this form you are in agreement with our Office Policy

Today's Date:___________________________________

Patient/Guarding Signature:____

Patient Printed Name:____

Guardian Relationship to Patient:____

****