PATIENT INFORMATION

Date ___________________________________

Name ____ Wishes to be called _______________________________

Birthdate____ Soc Sec#____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married

Address ____ City, State, Zip ______________________________________

Home # ____ Cell #____

Employer ____ Work #_______________________________ Ext_______

Where do you prefer to receive calls? ☐ Home ☐ Cell ☐ Work

E-mail Address ____ Referred by ______________________________________

My Dentist is ____

PERSON RESPONSIBLE FOR ACCOUNT

Name ____ Relationship to patient ___________________________

Birthdate ____ Soc Sec #____

Home Phone ____ Cell Phone____

Address ____ City, State, Zip ______________________________________

Employer ____ Work phone ______________________________ Ext_______

DENTAL INSURANCE INFORMATION

Primary Dental Insurance	***Secondary Dental Insurance or Medical PPO***
Insurance Company ____________________________________	Insurance Company ____
Group # ____	Group # ____
Name of Insured____	Name of Insured____
Employer ____	Employer ____
Relationship to Patient ____________________________________	Relationship to Patient ____
Insured DOB______________ Ins ID#__________________________	Insured DOB _____________ Ins ID#____________________________

All of the above information is correct. I understand that I am responsible for all costs of dental treatment. I authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I hereby authorize payment directly to Aurora Dental Specialists of the 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 my dependents. I understand that as a HIPPA compliant office, the use of cell phones, electronic devices and/or any recording devices is prohibited while in the operatory rooms and/or recovery rooms.

____ SIGNATURE OF PATIENT OR GUARDIAN

____ SIGNATURE OF INSURED AND/OR RESPONSIBLE PARTY

MEDICAL HISTORY

Patient name____ Age ________ Birthdate __________________

Height ________Weight __________ Are you currently under the care of a physician? Yes ____ No_____

If Yes, for what reason? ____

Physician's Name _________ ____________________________Phone _________________________________

Please list all medications that you are taking in the box to the right ⇨ ⇨ ⇨

List of all medications: including over the counter medications; vitamins and supplements:

____

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Have you ever taken prescription drugs for weight loss (i.e. PhenFen or Redux) Yes ___ No___

Have you ever taken medications for Osteoporosis (i.e. Fosamax, Aredia,Boniva) Yes___ No ___

Are you, or have you ever taken any "Blood Thinners" (i.e. Coumadin, Plavix, Xarelto, Pradaxa) Yes ___ No___

Do you currently, or have you had to, take antibiotics before dental treatment? Yes ___ No ___

ALLERGIES:

Are you allergic (or have had an adverse reaction) to: *Check all that apply*

Penicillin______ Codeine _______ Local Anesthetic ______ Latex _______ None __________

Other medications or substances ____

Have you had any unusual or unexplained reactions during a surgical procedure? Yes ____ No ____
If yes, please explain____

Hearing impaired? Yes _________ No _________

Do you have any of the following: (*Please mark Yes or No*)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery	☐	☐	Asthma	☐	☐	Artificial Joint	☐	☐	Hepatitis (A / B/ C)	☐	☐
Heart Murmur	☐	☐	Shortness of Breath	☐	☐	Dementia/Alzheimer's	☐	☐	Blood Transfusion	☐	☐
Heart pacemaker	☐	☐	Respiratory Ailments	☐	☐	Cancer	☐	☐	Ulcers	☐	☐
Rheumatic Fever	☐	☐	Tuberculosis	☐	☐	Radiation Therapy	☐	☐	Stomach Disorders	☐	☐
Rheumatic Heart Disease	☐	☐	Sinus Trouble	☐	☐	Chemotherapy	☐	☐	Organ Transplant	☐	☐
Congenital Heart Disease	☐	☐	Chronic Cough	☐	☐	Prolonged Bleeding	☐	☐	Glaucoma	☐	☐
Artificial Heart Valve	☐	☐	Thyroid problem	☐	☐	Leukemia	☐	☐	Steroid use	☐	☐
Mitral Valve Prolapse	☐	☐	Kidney problems	☐	☐	Blood Disorder	☐	☐	Arthritis/Rheumatism	☐	☐
High Blood Pressure	☐	☐	Sexually Transmitted Disease	☐	☐	Hemophilia	☐	☐	Neurological Disorder	☐	☐
Low Blood Pressure	☐	☐	HIV positive/AIDS/ARC	☐	☐	Anemia	☐	☐	Epilepsy	☐	☐
Sleep Disorders	☐	☐	Stroke	☐	☐	GERD	☐	☐	Osteoporosis	☐	☐
Sleep Apnea	☐	☐	Fainting Spells	☐	☐	Removal of Spleen	☐	☐	Botox/Cosmetic Filler	☐	☐
Diabetes	☐	☐	Anorexia/Bulimia	☐	☐	Liver Disease	☐	☐	Substance abuse/Alcoholism	☐	☐

Do you have a condition that is not listed that we should be aware of? If yes please note: ____

DR. COMMENTS: PREMEDICATION REQUIRED ☐

Do you currently smoke or use the following tobacco products?

Cigarettes _______ Cigars _______ Pipe ______ Chew _______ None_______

Have you used tobacco products in the past? Yes ___ No ___ If yes, how long ago? __________

Have you had any serious illness, hospitalization or accident? Yes ____ No_____

If yes, please explain: ____

Women:
Are you pregnant?Yes/No Due Date________
Are you taking contraceptives? Yes/ No
If yes, please note: ____________________

I understand the above information is necessary to provide me with dental care in a safe and efficient matter. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this doctor of any changes in my health or medication.

Patient's Signature____ **Date** ____________________________

(Signature of parent or guardian if a minor)

OUR FINANCIAL POLICY

Thank you for choosing Aurora Dental Specialists. Our mission is to deliver the best oral surgery care available.

Patients are expected to pay by cash, check, credit card or CareCredit the day that service is rendered unless specific arrangements have been made.

For those patients who are covered by insurance, we accept assignment of benefits. This means that you must sign the portion of your insurance form that "assigns" payments to our office. Most insurance plans do not cover 100% of the cost of treatment. You are expected to pay your ***estimated portion*** of the charges the day that services are rendered. We will *ESTIMATE* your portion, but until we actually receive payment from the insurance company, ***it is just an estimation***. Insurance benefits quoted may be reduced based on your employer's plan selection and whether we are a participating provider in your plan. You are ultimately responsible for all charges incurred in this office and obtaining information of participation of insurance plans.
For those patients that we are filing with medical PPO insurance, please keep in mind that benefits to be paid will first be applied to your annual deductible and only if they allow medical coverage for wisdom teeth and the position of such teeth. We will assist you in filing with your insurance company, but ultimately the responsibility lies with you.

Please feel free to ask any questions that may remain unanswered either before or after treatment.

I understand and agree to the above financial policy. I acknowledge I have reviewed a copy of this office's notice of privacy practices attached. (HIPPA)

Patient's Signature ____ Date ______________________________
(Parent or Guardian of a minor)

For patient's that are over the age of 18 and wish to have any information pertaining to treatment and/or payment information shared with their parent/guardian (whether by phone or in person) please sign here as consent to disclose information to the following names:

Patient's Signature ____ Date _________________________

Name ____ Relationship__________________________

Name ____ Relationship __________________________

Name ____ Relationship __________________________

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