Patient Information

Date_____

Name_____ Preferred Name _____ Birthdate _____

☐ Female ☐ Male ☐ Married ☐ Single ☐ Widow ☐ Minor ☐ Separated

Address_____ City_____ Zip_____

Phone #_____ Work #_____ Cell #_____

E-Mail_____ SS#_____-_____-_____

Name of Employer_____ Occupation_____

Who referred you to our office ?_____

Person to call for emergency _____Phone #_____

Responsible for Account

Name_____ Relationship_____

Address_____ Phone # _____

_____

Insurance Information

Primary Insurance	**Secondary Insurance**
Name of Insured _____	Name of Insured _____
Relationship to Patient_____	Relationship to Patient_____
Insured Birthday _____	Insured Birthday _____
SS # _____	SS # _____
Employer _____	Employer _____
Insurance Company_____	Insurance Company_____
Group # _____	Group # _____
ID # _____	ID # _____
Ins. Address_____	Ins. Address_____
_____	_____

Financial Policy

I understand that I am financially responsible for all charges regardless of insurance coverage. A12%annual finance charge will be applied to accounts over 90 days, unless prior arrangements have been made. As a courtesy, this office will assist with filing insurance claims. However the patient may need to contact their insurance company regarding questions of coverage. I authorize payment of insurance benefits to be paid to Robert J. Bastic.

Privacy Practice Consent

I have had full opportunity to read your Notice of Privacy Practices. I understand that by signing, I am giving my consent to your use and disclosure of protected health information for treatment, payment activities and healthcare operations.

Signature_____ **Date**_____

Family Physician or Clinic_____

Phone_____

Last physical exam_____

Are you under the care of a physician? Yes No

Treated for_____

_____

Does your Physician require antibiotics prior to having dental treatment? Yes No

Do you have or had :	**Yes**	**No**
Heart lesions or murmur	☐	☐
Artificial heart valves	☐	☐
Heart disease	☐	☐
Rheumatic fever	☐	☐
Cardiovascular disease	☐	☐
Pace maker	☐	☐
High/Low blood pressure	☐	☐
Blood Transfusion	☐	☐
Abnormal bleeding	☐	☐
HIV/Aids	☐	☐
Hepatitis A, B, or C (circle)	☐	☐
Diabetes	☐	☐
Anemia	☐	☐
Fainting	☐	☐
Venereal disease/STD	☐	☐
Osteoporosis	☐	☐
Arthritis/Joint pain	☐	☐
Fibromyalgia	☐	☐
Artificial Joints/Replacements	☐	☐
Sinus problems/Allergies	☐	☐
Asthma	☐	☐
Seizures	☐	☐
Thyroid problems	☐	☐
TMJ problems	☐	☐
Sleep Disorders/Apnea	☐	☐
Acid Reflux/GERDS	☐	☐
Psychiatric Disorder	☐	☐
Cancer _____	☐	☐

Other health issues not listed.

_____

_____

Patient Signature_____

Dentist Signature _____

Are you allergic to:	YES	NO
Penicillin	☐	☐
Other Antibiotics	☐	☐
_____		
Latex	☐	☐
Local Anesthetics/Novocain	☐	☐
Codeine or Narcotics	☐	☐
Metals	☐	☐

Other allergies not listed _____

_____

Are you taking any of the following medications?	**Yes**	**No**
Antibiotics	☐	☐
Blood Pressure	☐	☐
Blood thinners	☐	☐
Heart medication	☐	☐
Aspirin	☐	☐
Tranquilizers	☐	☐
Allergy	☐	☐
Steroids	☐	☐
Insulin	☐	☐
Bone Density	☐	☐

List any other medication including over the counter supplements_____

_____

_____

_____

Do you.....	**YES**	**NO**
Wear contacts	☐	☐
Wear hearing Aids	☐	☐
Smoke or use Tobacco	☐	☐

Women	**Yes**	**No**
Are you pregnant?	☐	☐
Oral Contraceptives/Hormones	☐	☐

Office use

Date	Hygienist	Patient