PATIENT MEDICAL HISTORY

Benjamin T. Peterson, DDS

Patient Name: ______________________ Date of Birth: __________

e-mail address: ______________________ *Contact Phone#:* __________

Medical Physician's Name: ______________________ Date of last medical exam: __________

Are you currently under medical treatment? ☐ Yes ☐ No If yes, please explain: __________

Have you been hospitalized for any surgical operation or serious illness in the last 5 years? ☐ Yes ☐ No
If yes, please briefly explain and give dates: __________

Have you ever taken medication for Osteoporosis? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No
Do you suffer from daytime sleepiness? ☐ Yes ☐ No
Have you ever been diagnosed with a sleep disorder or sleep apnea? ☐ Yes ☐ No
Have you had a sleep study? ☐ Yes ☐ No
Have you failed a CPAP? ☐ Yes ☐ No

Are you allergic to or have you had any reactions to the following:

Local anesthetics	☐ **Yes**	☐ **No**	**Sulfa drugs**	☐ **Yes**	☐ **No**
Penicillin	☐ **Yes**	☐ **No**	**Any metals**	☐ **Yes**	☐ **No**
Codeine	☐ **Yes**	☐ **No**	**Latex rubber**	☐ **Yes**	☐ **No**

Other: __________

Women Only:
Are you pregnant or think you might be pregnant? ☐ Yes ☐ No If Yes, estimated due date: __________
Are you nursing? ☐ Yes ☐ No
Are you taking oral contraceptives? ☐ Yes ☐ No

Please list any medications you are taking, including non-prescribed medications, and the dosage you are taking:

__________ __________ __________

__________ __________ __________

__________ __________ __________

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

	Yes	No		Yes	No		Yes	No
Low blood pressure	☐	☐	Epilepsy/convulsions	☐	☐	Hepatitis/Jaundice	☐	☐
High blood pressure	☐	☐	Diabetes	☐	☐	Sexually Trans Disease	☐	☐
Heart Attack	☐	☐	Kidney disease	☐	☐	AIDS/HIV	☐	☐
Heart Disease	☐	☐	Thyroid problems	☐	☐	Ulcer/Stomach Trouble	☐	☐
Artificial heart valve	☐	☐	Respiratory problems	☐	☐	Stroke	☐	☐
Heart murmur	☐	☐	Emphysema	☐	☐	Cancer	☐	☐
Mitral valve prolapse	☐	☐	Hay fever/Allergies	☐	☐	Radiation therapy	☐	☐
Pacemaker	☐	☐	Anemia	☐	☐	Recent weight loss	☐	☐
Circulatory problems	☐	☐	Back problems	☐	☐	Liver disease	☐	☐
Fainting/Seizures	☐	☐	Arthritis	☐	☐	Osteoporosis	☐	☐
Asthma	☐	☐	Artificial joints	☐	☐	Other: __________		
Tobacco use	☐	☐	Weight loss medication	☐	☐			

Signature of Patient or Responsible Party ______ Date ______ Blood Press ______ Pulse ______

Signature of Patient or Responsible Party ______ Date ______ Blood Press ______ Pulse ______

Signature of Patient or Responsible Party ______ Date ______ Blood Press ______ Pulse ______

PATIENT INFORMATION Date: ___________

Patient Name: ______________________________

Address: ______________________________

City: ________________ State:____ Zip: ______

Gender: □ Male □ Female Age: ______

Birthdate: ___________ SSN: ________________

□ Married □ Single □ Other □ Minor

Patient Employer: ______________________________

Email address: ______________________________

Spouse or Parent(s) Name:

____

Whom may we thank for referring you to our office?

____

DENTAL INSURANCE

Insurance Company: ______________________________

Subscriber's Name: ______________________________

Birthdate: ________________ SSN: ________________

Policy/ID#: ________________ Group#: ___________

Relationship to patient: ______________________________

SECONDARY INSURANCE? □ Yes □ No

Insurance Company: ______________________________

Subscriber's Name: ______________________________

Birthdate: ________________ SSN: ________________

Policy/ID#: ________________ Group#: ___________

Which number would you prefer to be reached at? Home Cell Work

Home: ________________ Cell: ________________ Work: ________________

Emergency Contact: ________________ Relationship: ____________ Phone: ______________

PAYMENT POLICY Payment is expected at the time services are rendered unless prior arrangements have been made. We expect that your account will be cleared within 60 days. If financial arrangements have been made, the remaining unpaid balance may be subject to a FINANCE CHARGE at the ANNUAL PERCENTAGE RATE of 18%. There will be a $25 fee for all returned checks.

INSURANCE ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have the insurance coverage referenced above and assign directly to Benjamin T. Peterson, DDS, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Benjamin T. Peterson, DDS, PC, may use my health care information and may disclose such information to the above-named insurance company and its agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This release of information will remain in effect until revoked by me in writing.

____
Signature of Patient or Responsible Party

____
Please print name of Patient or Responsible Party

____
Date

____
Relationship to Patient

DENTAL HISTORY

Reason for today's visit: ______________________________

Former Dentist: ______________________________

Date of last dental visit: ______________________________

Date of last dental x-rays: ______________________________

Are you happy with the condition of your teeth? □Yes □ No

If not, why? ______________________________

____

____

____

Check (√) if you have had problems with any of the following:

□ Bad breath
□ Bleeding gums
□ Clicking or popping of the jaw
□ Food collection between teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Grinding teeth
□ Sensitivity to cold
□ Snoring
□ Sensitivity to hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores or growths in mouth

PATIENT FINANCIAL POLICY

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options.

1. Payment in Full
2. Short Term Payment Options
3. 3rd Party Payment Plan

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed, by you, to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. **I understand that all services are due to be paid within sixty (60) days of date of service, regardless of whether or not my insurance benefits have been received. 3/4 of one percent (.75%) per month interest, nine percent (9%) per year will be charged on accounts 60 days from treatment date.** I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

Please make your questions and concerns known to our Financial Coordinator who is happy to discuss this policy and ensure that you have an outstanding experience.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

____

Print Patient Name   Date   Signature (responsible party)