Patient Information
Name: ______________________________________
Gender:__________ **Family Status:** __________
Address: ____________________________________
____
Phone (Home): __________ **(Mobile):** ___________
(Work):______________ **(EXT):** _____
Email: ______________________________________
S.S. #: ________________ **Date of Birth:** ___________

Medical Doctor's Name: __________________
Phone: _________________________________
Doctor's Address: ________________________
Date of Last Visit: ________________________
IN CASE OF EMERGENCY, PLEASE CALL:
Name: _______________________________
Phone: ______________________________
Relationship: __________________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________________________ Occupation: ______________________

Address: ____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #: _______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

Insurance Plan Name and Address: _____________________________________

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____________________

Insurance Plan Name and Address: ____

What is the reason for today's visit? ____

Have you had any complications associated with any dental treatment or anesthesia? ________

HEALTH HISTORY INFORMATION

For each of the following conditions, please check which ever applies.

Cardiovascular

- High Blood Pressure
- Heart Attack
  Date: _____________
- Heart Murmur
- Rheumatic Heart Disease
- Congestive Heart Failure
- Arrhythmia
- Pacemaker
- Angina
- Defibrillator
- Coronary Bypass
- Coronary Angioplasty
- Artificial Heart Valve
- Heart Transplant
- Stroke
- Do you have shortness of breath, chest pain, Dizziness?

Genitourinary

- Kidney or bladder problems
- Dialysis
- Kidney transplant
- Sexually transmitted disease

Neurologic

- Vision problems
- Hearing problems
- Glaucoma
- Headaches
- Bipolar
- Schizophrenia
- Epilepsy/seizures
- Alzheimers
- Other _____________

Hematologic (Blood Disorders)

- Anemic
- Iron Deficiency
- HIV/AIDS
- Sickle Cell Anemia
- Leukemia
- Lymphoma
- Do you bruise easily, get frequent infections, heal slowly?

Endocrine

- Diabetes
- Thyroid disease
- Excessive urination, thirst, or hunger?
- Recent weight gain or loss unintentionally?

Skin

- Skin Cancer
- Skin rashes
- Itchiness, sores, other skin Problems?

Musculo/Skeletal

- Osteoarthritis
- Rheumatoid Arthritis
- Lupus
- Artificial (Prosthetic) Joints: date__________
- Do you experience muscle joint or back pain?

Pulmonary (Lung)

- Seasonal Allergies
- Environmental Allergies (smoke, dust, etc.)
- Sinus problem
- Asthma
- Emphysema
- Tuberculosis
- Do you have a cough, Wheezing, breathing difficulties?

Gastrointestinal

- Stomach ulcer
- Reflux
- Colitis/Crohn's
- Irritable Bowel
- Hepatitis
- Cirrhosis
- Eating disorder
- Frequent heart burn, diarrhea, vomiting?

Cancer

- Have you ever had Surgery, chemotherapy or radiation treatment for cancer?
- If yes, was the cancer in your mouth, head or neck? Please explain on following page.

Do you have any medical problems not listed on the previous page? If yes, please list.

Do you have any family history of heart disease, diabetes or immunologic disease, like lupus, etc? If yes, please list.

Have you been hospitalized or had any operations/surgery in the past 5 years? If yes, please list.

Have you ever taken a bisphosphonate drug, such as Aredia, Fosamax, Zometa, Boniva or Actonel, for osteoporosis or cancer therapy?

Do you have any food or drug allergies? (Example medications, foods, dyes, latex, etc.)

List all medications prescribed by your doctor, including birth control pills and hormone supplements.

List all non-prescription (over-the-counter) medications, vitamins & herbal supplements that you are taking or have taken in the last month.

Social history

Do you currently smoke cigarettes?______ How many/day? _____ How many years? _________

For former smokers: Quit date: __________ How many/day? _____ How many years? _________

Do you drink alcohol? _________ How often? __________

Do you use recreational drugs? _______ What/How often? _________

Are you recovering from any drug or alcohol addictions, if so please explain?

For **Women** Only: Are you pregnant or possibly pregnant? **Yes** **No** Are you nursing? **Yes** **No**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medicines change, I will inform the dentist at the next appoinment without fail.

Patient, Parent, or Guardian Signature

Print Name

Welcome To Laser Dentistry of Erie

We are pleased to welcome you to our family of patients. We are committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimum oral health. Our team would like to ensure that your visit will be pleasant and informative while striving to provide the best possible dental care for each patient and their families.

Our goal is to be your partner in health for a lifetime. We at Laser Dentistry of Erie take our responsibility and commitments to you very seriously. Building a relationship with you and your family is one of our highest priorities. Our team is available to answer all of your questions and alleviate any concerns you may have. They have been trained to assist you in every way, including the navigation of your insurance coverage. May we ask that you strive for the following:

- To communicate your concerns, needs, and wants to our dental team allowing us to provide you with the utmost comfort during any required procedure.
- To be committed to the appointment time you have reserved or notify us at least 48 hours in advance should you need to change an appointment. If adequate notice is not given, we reserve the right to charge a fee of $25.00. (See bold note below for information on evening appointments.)
- To be prepared with the appropriate fee and/or your co-payment at each appointment as services are rendered. For all fees due, we accept: cash, checks, bank debit cards, Visa, Mastercard, Discover and Care Credit. **Any fees overdue more than 30 days will be assessed a finance charge.**
- To know that as a COURTESY, our office will file your claim with your insurance company, and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow; however, if we do not receive payment from your insurance company within 60 days, the payment becomes your responsibility. **If you prefer to have a predetermination sent to your insurance, please notify our office before scheduling your appointment.**
- To know the patient is always responsible for seeing the ENTIRE FEE is paid in full. Laser Dentistry of Erie reserves the right to file a dispute with the district court or an outside collection agency if your account carries an unpaid balance for more than 90 days without prior arrangement with Laser Dentistry of Erie. You are responsible for any and all fees we incur trying to collect an unpaid balance.
- All paperwork in this office may be stored in digital format. Any signatures stored in this format will be considered as valid as the original. Paper documents with sensitive information are shredded (after a digital copy is made) and a certificate of proper destruction is available upon request.
- **As a courtesy to our patients, we offer evening appointments on Thursday's. Due to the popularity of these evening appointments we request at least a 48 hour notice of cancellation. Without this notice a $50.00 cancelled appointment fee will apply and be strictly enforced. Also, please note that another evening appointment may not be available at the time of rescheduling.**

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected heath insurance information to carry out payment activities in connection with this claim.

PRINT NAME ______________________________ DATE ______________________

SIGNATURE ______________________________