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: _____

HEALTH HISTORY INFORMATION

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

Cardiovascular

- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Arteriosclerosis
- ○ Heart Attack
  Date: _____
- ○ Rheumatic Heart Disease
- ○ Previous Infective Endocarditis
- ○ Damaged Heart Valves
- ○ Artificial Heart Valves
- ○ Congestive Heart Failure
- ○ Arrhythmia
- ○ Pacemaker
- ○ Angina
- ○ Defibrillator
- ○ Coronary Bypass
- ○ Coronary Angioplasty
- ○ Heart Transplant
- ○ Stroke
- ○ Aneurysm
- ○ Do you have shortness of breath, chest pain, Dizziness upon exertion?

Genitourinary

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

Neurologic

- ○ Vision problems
- ○ Hearing problems
- ○ Glaucoma
- ○ Headaches
- ○ Bipolar
- ○ Schizophrenia
- ○ Epilepsy/seizures
- ○ Alzheimers
- ○ Eating Disorders
- ○ Fainting
- ○ Other _____

Hematologic (Blood Disorders)

- ○ Anemic
- ○ Iron Deficiency
- ○ HIV/AIDS
- ○ Sickle Cell Anemia
- ○ Leukemia
- ○ Lymphoma
- ○ Abnormal Bleeding
- ○ Hemophilia
- ○ Autoimmune Diseases
- ○ Do you bruise easily, get frequent infections, heal slowly?

Endocrine

- ○ Diabetes I or II? _____
- ○ 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 chronic muscle joint or back pain?

Pulmonary (Lung)

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

Gastrointestinal

- ○ Stomach ulcer
- ○ Reflux
- ○ Colitis/Crohn's
- ○ Irritable Bowel
- ○ Hepatitis
- ○ Cirrhosis
- ○ Other Gastrointestinal Diseases
- ○ 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 above? 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 for treatment of osteoporosis or cancer? such as:

- ○ Aredia
- ○ Fosamax
- ○ Zometa
- ○ Boniva
- ○ Actonel
- ○ Other_____

Are you allergic to or have you had a reaction to: (Please specify type of reaction to all **Yes** responses.)

- ○ Local Anesthetics_____
- ○ Aspirin_____
- ○ Penicillin _____
- ○ Clindamycin _____
- ○ Other antibiotics_____
- ○ Sulfa Drugs _____
- ○ Codeine _____
- ○ Other Narcotics_____
- ○ Metals _____
- ○ Latex (Rubber) _____
- ○ Iodine_____
- ○ Food _____
- ○ Other _____

List <u>all medications</u> 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? _____

Do you currently use smokless tobacco? _____ How Often?_____How many years?_____

For former Tobacco Users: Quit date: _____

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**

Dental Information

- ○ Gums bleed when brush and floss?
- ○ Teeth sensitive to cold, hot, sweets or pressure? (Please circle)
- ○ Dry mouth?
- ○ Previous periodontal (gum) treatment?
- ○ Previous orthodontic treatment (braces?)
- ○ Earaches or neck pain?
- ○ Popping, clicking or discomfort in jaw?
- ○ Grind your teeth?
- ○ Sores or ulcers in mouth?
- ○ Wear dentures or partials? (Please circle)
- ○ Serious injury to head or mouth?_____

Date of last dental examination**:** _____

What is the reason for today's visit? _____

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

_____

Has a physician or previous dentist ever recommended that you take antibiotics prior to your dental treatment?_____ Reason:_____

How do you feel about your smile? Is there anything you would change if you could?

_____

_____

_____

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 appointment without fail.

_____

Patient, Parent, or Guardian Signature

_____

Print Name

_____

Date

Laser Dentistry of Erie Financial Policy

Thank you for choosing Laser Dentistry of Erie. Our primary mission is to deliver the best and most comprehensive dental care available. We 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. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- **Cash, Check, Visa, MasterCard** or **Discover Card**
- Convenient Monthly Payment Plans from **Care Credit and Citi Health,** which allow you to pay over time with no annual fees or pre-payment penalties.
- For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

In order to help us provide you the best possible care, may we ask that you strive for the following:

- Communicate your concerns, needs, and wants to our dental team allowing us to provide you with the utmost comfort during any required procedure.
- We understand that illness, emergencies, flat tires, bad weather, etc. do occur. Whenever possible, we ask that you are committed to the appointment time you have reserved or notify us at least 24 hours in advance should you need to change an appointment. Failure to do so may result in a failed appointment charge.
- A fee of $30 may be charged for patients who miss or cancel their appointment without 24 hour notice. This includes appointments made or confirmed using any medium to do so. (Including, but not limited to Phone, Email, Text Messaging, and Internet.)
- As a courtesy to our patients, we offer evening appointments on Thursday's. Without proper notice of cancellation, a $50.00 cancelled appointment fee will apply. Also, please note that another evening appointment may not be available at the time of rescheduling.
- Three failed appointments without notice or constant cancelling of appointments with short notice will result in dismissal from our office.
- Be prepared with the appropriate fee and/or your co-payment at each appointment as services are rendered. **Any fees overdue more than 30 days will be assessed a finance charge of 20.000%.**
- 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 (including but not limited to: postage, certified letter charges, court fees, outside collection agency fees, etc.)
- Patients/families with outstanding balances of 90 days or more without prior payment arrangement will be subject to dismissal from the practice.
- 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 destroyed appropriately after digital copies are properly stored.

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 _____