PATIENT INFORMATION

GENERAL INFORMATION

Patient First Name _____Middle Initial ___Last Name _____Nickname_____
□ Male □ Female Date of Birth _____ Social Security Number _____
Address _____ City _____ State _____ ZIP _____
Email_____ Home Phone _____Cell Phone _____
Employer_____ Occupation_____ Work Phone _____
Married □ Single □ Divorced □ Spouse's Name: _____
Emergency Contact _____ Relationship _____ Phone # _____

IF PATIENT IS A MINOR

Responsible Party _____ Relationship to Patient _____

HOW DID YOU HEAR ABOUT US?

□ Social Media □ Insurance □ Website □ Internet □ Family/Friend/Coworker □ Other

Who may we thank for your visit today? _____

COMMUNICATION

Sisson Family Dentistry has permission to contact me with appointment reminders or other communication via the following (check all that apply):

□ Text □ Email Preferred Phone #: □ Home □ Cell □ Work

DENTAL INSURANCE INFORMATION

Primary Insurance Information
Insured's Name _____
Insured's Employer _____
Insured's DOB _____
Insurance Company _____
Insurance Phone # _____
ID # _____ Group # _____

Secondary Insurance Information (if applicable)
Insured's Name _____
Insured's Employer _____
Insured's DOB _____
Insurance Company _____
Insurance Phone # _____
ID # _____ Group # _____

MUST SIGN FOR OFFICE TO FILE INSURANCE ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received/been offered a copy of the office's Notice of Privacy Practices.

I authorize the following person(s) to have access to my protected health information covered under the Privacy Practices:

Name (Printed)_____ Relationship _____
Name (Printed)_____ Relationship _____
Name (Printed) _____ Relationship _____

SIGNATURE

Patient Name (Printed) _____
Patient/Guardian Signature _____ Date _____

OVER

DENTAL HEALTH HISTORY

Patient Name: _____ Birthdate:_____
Preferred Pharmacy: _____ Pharmacy Phone: _____

DENTAL HISTORY

Reason for Today's Visit: _____ Date of last cleaning:_____
Former Dentist: _____ Date of last dental x-rays: _____

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

□ Bad Breath	□ Grinding teeth/Jaw pain	□ Sensitivity
□ Bleeding gums	□ Loose teeth	□ Broken teeth/fillings
□ Clicking or popping jaw	□ Periodontal treatment	□ Sores/growths in mouth
□ Dry mouth	□ Food collection between teeth	□ Discolored teeth
□ Crowded teeth	□ Spaces between teeth	□ Missing teeth

How often do you floss? _____ How often do you brush? _____
Is there anything you would like to change about your smile? _____

MEDICAL HISTORY

Physician's Name _____ Date of last Visit _____
Have you had a serious illness or hospitalization in the past 5 years? □ YES □ NO
If yes, explain _____
Have you ever taken any bisphosphonate medications? □ YES □ NO
Are you taking any blood thinner medications? □ YES □ NO
Women: Are you pregnant? □ YES □ NO Nursing? □ YES □ NO
Do you use: Tobacco □ YES □ NO Type _____ Frequency _____
Alcohol □ YES □ NO Frequency_____
Other Drugs □ YES □ NO Type_____ Frequency _____

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

□ Anemia	□ Cancer (Type _____)	□ Heart Attack	□ Liver Disease
□ Anxiety	□ Dementia	□ Heart Problems	□ Pacemaker
□ Arthritis	□ Depression	□ Heart Surgery	□ Respiratory Disease
□ Artificial Heart Valve	□ Diabetes	□ Hepatitis	□ Seizures
□ Artificial Joints	□ Fainting	□ High/Low Blood Pressure	□ Shortness of Breath
□ Asthma	□ GERD	□ HIV/AIDS	□ Stomach Ulcers
□ Bleed easily	□ Glaucoma	□ HPV	□ Stroke
□ Blood disorders	□ Headaches	□ Kidney Disease	□ Thyroid Problems
□ Other _____			□ Tuberculosis

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____

ALLERGIES

□ Aspirin	□ Penicillin
□ Advil	□ Sulfa
□ Codeine	□ Latex
□ Local Anesthetic	□ Other _____
□ Other _____	□ Other _____

NEXT PAGE

The information on this form is accurate and complete to the best of my knowledge and is only used in my treatment, billing, and processing of insurance benefits. I agree to pay for all professional fees and treatment not covered by my dental insurance. I realize that Sisson Family Dentistry will file my insurance claim as a courtesy and that I am responsible for full payment of fees not paid by my insurance company within 60 days from that date of service. I further agree to pay any collection fee, attorney fees, and court costs should these means of collection become required. I will not hold the dentist or any of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Cancellation Policy

Sisson Family Dentistry requires 24-hour notice for cancelled or failed appointments. Any appointment less than 90 minutes is subject to a $50 cancellation fee. Any appointment 90 minutes or more is subject to a $75 cancellation fee. This fee will be required to be paid before any future appointments can be made. After **3** cancelled or failed appointments, our office reserves the right to not schedule any further appointments.

Patient/Guardian Signature_____ Date: _____