Patient Information Form

Today's Date _____/_____/_____

Please Print

Home Phone # ________________________

Cell Phone # ________________________

Work Phone # ________________________

Patient's Full Name / Sex / Age / Birthdate / Social Security Number

Address / City / State / Zip Code

Patient's Employer or School / Spouse's Name / Spouse's Employer & Phone #

Mother's Name (If Child) & Phone #, if different than above / Father's Name (If Child) & Phone #, if different than above

Mother's Employer & Phone # / Father's Employer & Phone #

Pharmacy That You Use, Location & Phone #

In Case of Emergency Contact & relationship to patient / Phone # / Family Doctor's Name

Referring Dentist / Reason for Visit / Family Members Who Have Been Patients Here

INSURANCE INFORMATION

PRIMARY

Dental Ins. Co. ________________________

ID # & Group # ________________________

Policy Holder's Name ________________________

Policy Holder's Birthdate ________________________

Policy Holder's Social Security # ________________________

Medical Ins. Co. ________________________

ID # & Group # ________________________

Policy Holder's Name ________________________

Policy Holder's Birthdate ________________________

Policy Holder's Social Security # ________________________

SECONDARY

Dental Ins. Co. ________________________

ID # & Group # ________________________

Policy Holder's Name ________________________

Policy Holder's Birthdate ________________________

Policy Holder's Social Security # ________________________

Medical Ins. Co. ________________________

ID # & Group # ________________________

Policy Holder's Name ________________________

Policy Holder's Birthdate ________________________

Policy Holder's Social Security # ________________________

AUTHORIZATION OF TREATMENT AND TO RELEASE INFORMATION

I hereby authorize the above named surgeon(s) to provide treatment and any insurance company(s) and consulting health care professionals information concerning health care, advice, treatment or supplies provided the information will be used exclusively for the purpose of evaluation, treatment and administering claims for benefits.

________________________ Patient or Legal Guardian's Signature

________________________ Date

HEALTH HISTORY

Patient's Name ______ Date of Birth ______ Date ______

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? .... Y N
2. Has there been any change in your general health in the past year? .... Y N
3. Date of last physical exam ______
4. Are you now under a physician's care for a particular problem? .... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: .... Y N

______

6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease? .... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness .... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y N
   - H. Kidney Disease? .... Y N
   - I. Diabetes? .... Y N
   - J. Thyroid Disease (Goiter)? .... Y N
   - K. Arthritis? .... Y N
   - L. Stomach Ulcers or Colitis? .... Y N
   - M. Glaucoma? .... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .... Y N
   - O. Radiation (X-ray) treatment for Cancer? .... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? .... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? .... Y N
   - B. Anticoagulants (Blood Thinners)? .... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? .... Y N
   - E. Steroids (Cortisone, etc.)? .... Y N
   - F. Tranquilizers .... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? .... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: ______

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9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .... Y N
   - B. Penicillin or other antibiotics? .... Y N
   - C. Sedatives, Barbiturates? .... Y N
   - D. Aspirin or Ibuprofen? .... Y N
   - E. Codeine or other pain killers? .... Y N
   - F. Latex or Rubber Products? .... Y N
   - G. Other allergies or reactions? Please, list .... Y N

______

10. Do you smoke or chew Tobacco? .... Y N
    How much per day? ______
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y N
12. Have you had any serious problems associated with any previous dental treatment? .... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? .... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
15. Do you wish to talk to the doctor privately about anything? .... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? .... Y N
    - B. Are you nursing? .... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date ______ Signature of Person Completing Health History ______ Doctor's Initials ______

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Medical Update: I have ready my Health History dated ______ and confirm that it adequately states past and present conditions.

Date ______ Exceptions or changes ______ Patient's Signature ______ Doctor's Initials ______

Date ______ Exceptions or changes ______ Patient's Signature ______ Doctor's Initials ______

JOHN F. SEIDEL, D.D.S., P.A.

1346 S. DIVISION ST., STE. 102
SALISBURY, MD 21804
410-749-6822

FINANCIAL POLICY

- In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.
- Your insurance policy is a contract between you and your insurance company; the doctor is 110t involved.
- We have made prior arrangements with many health plans to accept an assignment of benefits. We will bill those plans with whom we have an arrangement and will only require you to pay the authorized copayment, coinsurance, or deductible at the time of service.
- If you have insurance coverage with a plan that we do not have a prior agreement, payment of half is expected at the time of service, we may prepare and file the insurance claim, as a courtesy. However, if your insurance company does not pay the practice within a reasonable length of time (30 days), we will have to look to you for payment.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or "not medically necessary", **you will be responsible for the complete charge.** Payment is due at the time of service.
- Unless other arrangements have been made in advance, **payment in full** for examinations is due at the time of service. For your convenience we will accept VISA, MasterCard, and Discover. All personal checks in the amount of $50 and over require a driver's license number and will be authorized by Telecheck.
- The patient and/or legal guardian is responsible for all fees, including collection fees and/or attorney fees, court costs, and interest (1.5%) per month; 18.0% per year added to accounts over 30 days old. Attorney fees are 33.3% of outstanding balance. There is a $35.00 charge for all returned checks.
- For all services rendered to minor patients, we will look to the parent and /or legal guardian who signed the authorization for treatment, regardless of any legal binding agreement in the case of custody arrangements, for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

____ ________________________________
Signature of Patient or Legal Guardian Date

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Please Print the Name of the Patient