Patient Information

Patient Name: ____ Date: ______________
First Last MI

Social Security #: __________________________ Birth Date: ________________ Gender: ___________

Phone # (Home): ___________________ (Cell): ____________________ (Work): ___________________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of last dental visit: _____________________ Reason for this visit: _____________________________

Have you ever had any of the following? Please check those that apply:

- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ HIV or AIDS
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Pregnancy
  Due date: __________
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatic Heart Disease
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Codeine Allergy
- ❑ Penicillin Allergy
- ❑ Clindamycin Allergy
- ❑ Sulfa Allergy
- ❑ OTHER:
  ____
  ____
  ____

Are you currently taking any medications? ❑ Yes ❑ No

If yes, please list: ____

____

Are you now under the care of a physician? ❑ Yes ❑ No

If yes, please list: ____

____

Name of Physician: ____ **Phone:** ____________________

Do you have any other health problems? ❑ Yes ❑ No

If yes, please explain: ____

Have you ever had any complications following dental treatment? ❑ Yes ❑ No

If yes, please explain: ____

To the best of my knowledge, all the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctor(s) at the next appointment without fail.

____ ____________________
Signature of Patient, Parent or Guardian Date

Dental Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ❑ Yes ❑ No

Insured's Birth Date: __________________ ID/SS #: __________________ Group #: ___________________

Insured's Address: ____

____

Insured's Employer Name: ____

Insurance Plan Name and Address: ____

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____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary

Name of Insured: ____ Is insured a patient? ❑ Yes ❑ No

Insured's Birth Date: __________________ ID/SS #: __________________ Group #: ___________________

Insured's Address: ____

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Insured's Employer Name: ____

Insurance Plan Name and Address: ____

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____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Patient Financial Policy

Thank you for choosing Dr. Elizabeth Joseph, DDS, PLLC, as your dental provider. We are committed to providing you with the highest quality of care. We ask that you read and sign this to acknowledge your understanding of our patient financial policies.

You are ultimately responsible for the payment of treatment and care. The office will bill your insurance for you. However, you, the patient or guardian, are required to provide the most correct and updated information regarding dental insurance. You are also financially responsible for any deductible, co-insurance or any non-covered services. Co-payments are due at time of service. In the event that your dental insurance plan determines a service to be "not payable", you will be responsible for the complete charge and agree to pay the costs of all services provided. If you are uninsured, you are responsible to pay for any services provided at the time of service. Any overdue statements are due 30 days from receipt of billing.

I have read, understand, and agree to the provisions of the Patient Financial Policy.

____ ______________________

Signature of Patient, Parent or Guardian Date