StacyGodes DDS
AndreaBlum DDS, MS

THANK YOU FOR SELECTING OUR DENTAL TEAM

To help us meet your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION [CONFIDENTIAL]

Patient Number ____________________

Name ____________________ Date ____________________

SS#/SIN ____________________ Birthdate ____________________ Home Phone ____________________

Address ____________________ City ____________________ State/Prov. ____________________ Zip/P.C. ____________________

Email ____________________ Cell Phone ____________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College ____________________ City ____________________ State/Prov. ____________________ ☐ Full Time ☐ Part Time

Patient of Parent/Guardian's Employer ____________________ Work Phone ____________________

Business Address ____________________ City ____________________ State/Prov. ____________________ Zip/P.C. ____________________

Spouse or Parent/Guardian's Name ____________________ Employer ____________________ Work Phone ____________________

How Did You Hear About Us? (Referral/Name, Yelp, Google, Facebook, etc.) ____________________

Emergency Contact ____________________ Phone ____________________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ____________________ Relationship to Patient ____________________

Address ____________________ Home Phone ____________________

Email ____________________ Cell Phone ____________________

Driver's License # ____________________ Birthdate ____________________ Financial Institution ____________________

Employer ____________________ Work Phone ____________________ SS#/SIN ____________________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card: ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

INSURANCE INFORMATION

Name of Insured ____________________ Relationship to Patient ____________________

Birthdate ____________________ SS#/SIN ____________________ Date Employed ____________________

Name of Employer ____________________ Union or Local # ____________________ Work Phone ____________________

Employer Address ____________________ City ____________________ State/Prov. ____________________ Zip/P.C. ____________________

Insurance Company ____________________ Group # ____________________ Policy/ID # ____________________

Ins.Co. Address ____________________ City ____________________ State/Prov. ____________________ Zip/P.C. ____________________

How Much is Your Deductible? ____________________ How Much Have You Used? ____________________ Max Annual Benefit ____________________

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured ____________________ Relationship to Patient ____________________

Birthdate ____________________ SS#/SIN ____________________ Date Employed ____________________

Name of Employer ____________________ Union or Local # ____________________ Work Phone ____________________

Employer Address ____________________ City ____________________ State/Prov. ____________________ Zip/P.C. ____________________

Insurance Company ____________________ Group # ____________________ Policy/ID # ____________________

Ins.Co. Address ____________________ City ____________________ State/Prov. ____________________ Zip/P.C. ____________________

How Much is Your Deductible? ____________________ How Much Have You Used? ____________________ Max Annual Benefit ____________________

See Next Page

PATIENT MEDICAL HISTORY

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain ______________________	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? ______________________	☐	☐
4. Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?	☐	☐
5. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8. Are you wearing contact lenses?	☐	☐
9. Do you or have you had any of the following?		

	Yes	No
10. Are you allergic to or have you had any serious reactions to the following?	☐	☐
Local Anesthetics (e.g.Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g.nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________________	☐	☐
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers/IBS	☐	☐	Other ______________	☐	☐

PATIENT DENTAL HISTORY

Name of Previous Dentist ______________________ Date of Last Exam ______________________

Previous Dentist's Location ______________________ Date of Last Cleaning ______________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel any pain in your teeth?	☐	☐
5. Do you have any sores or lumps in/near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any or the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement ______________	☐	☐
15. Have you ever received oral hygeine instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

PATIENT DENTAL HISTORY-UPDATE

Please note any changes in medical history ______________________

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AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be repsonsible for payment of all services rendered on my behalf or my dependents.

X______________________

Signature of patient (or parent/guardian if minor)

Doctor's Comments ______________________

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______________________ Signature ______________________ Date ______________

Comprehensive Financial Policy

1) **Missed Appointments**: *Please call us 48 hours before your appointment time to reschedule or cancel your appointment. A $50.00/hour charge will be applied for appointments rescheduled or cancelled less than 48 hours.*

2) **Co-Payments**: *Co-Pays are due at the time of your appointment. Our office accepts most major credit cards and checks.*

3) **Insurance Deductibles**: *If you have not met your deductible for the plan year, you will be required to pay at that time.*

4) **Insurance Cards**: *Please provide us with the correct dental insurance card and complete insurance information at time of visit.*

5) **Insurance Policies**: *As a courtesy, we will file your primary and secondary insurance policies and allow 30 days for payments on your account. On the day of service we will collect only a portion of the fee charged for the services rendered. However, you are ultimately responsible for payment of services not covered by insurance plan. It is your responsibility to call and check with your insurance as to which services are covered. Any balance left on the account after the insurance payment is received is the responsibility of the financial guarantor.*

6) **Cosmetic Services:** *Cosmetic services must be paid at the time of your visit. These services cannot be billed to your insurance.*

By signing below you agree and understand the above described financial policy. Thank You.

***Signature*______________________________________*Date*____________________________**

I acknowledge that I have received from Dr. Stacy Godes and/or Dr. Andrea Blum a copy of Dental Material Fact Sheet and HIPAA forms dated July 15, 2013.

***Signature*______________________________________*Date*____________________________**