PATIENT INFORMATION

Name: _____ Date: _____
Last First MI

___Male ___Female ___Married ___Single ___ Child ___Other Birth Date: _____

Address: _____Apartment #:_____

City_____State_____Zip_____

Phone (Home):_____Work: _____ Cell: _____

Social Security #: _____ E-mail:_____

Employer: _____Occupation:_____

Who may be thank for referring you? _____

In case of emergency, who should be notified? _____Phone_____

HEALTH INFORMATION

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

___Aids/HIV	___Excessive bleeding	___Liver Disease	___Stroke
___Allergies _____	___Fainting	___Mental Disorders	___Tuberculosis
_____	___Glaucoma	___Nervous Disorders	___Tumors
___Anemia	___Growths	___Pacemaker	___Ulcers
___Arthritis	___Hay Fever	___Pregnancy	___Venereal Disease
___Artificial Joints	___Head Injuries	Due Date_____	___Codeine Allergy
___Asthma	___Heart Disease	___Radiation Therapy	___Penicillin Allergy
___Blood Disease	___Heart Murmur	___Respiratory Problems	OTHER:
___Cancer	___Hepatitis	___Rheumatic Fever	_____
___Diabetes	___High Blood Pressure	___Rheumatism	_____
___Dizziness	___Jaundice	___ Sinus Problems	
___Epilepsy	___ Kidney Disease	___ Sleep Apnea **	___Stomach Problems

Have you ever had any complications following dental treatment? ___Yes ___No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ___Yes ___No
If yes, please explain: _____

Are you under the care of a physician? ___Yes ___No
If yes, please explain: _____

Name of Physician: _____Phone:_____

PLEASE LIST <u>ALL</u> MEDICATIONS & THE DOSAGE YOU ARE PRESENTLY TAKING:

_____
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors and/or staff at the next appointment.

_____ _____
Signature of patient, parent or guardian **Date**

DENTAL QUESTIONNAIRE

Name: _____ Date: _____

Answering the following questions will allow us to render optimum health service on an individual basis, providing the care appropriate for your needs. Your answers are for our records only and will be considered **confidential.**

1. Purpose of dental appointment:
   _____
2. Are you having any discomfort at this time?
   _____
3. When was your last dental appointment?
   _____
4. What was done at this visit?
   _____
5. When was your last dental cleaning?
   _____
6. Have you ever experienced: (please circle)

Extraction complications	___YES ___NO	Clenching or grinding of teeth	___YES ___NO
Sores or lumps in mouth	___YES ___NO	Braces (orthodontia)	___YES ___NO
Difficulty chewing	___YES ___NO	Bleeding gums	___ YES __ NO
Clicking or locking of the jaw	___YES ___NO	Gum (Periodontal Treatment)	___ YES ___NO
Jaw pain	___YES ___NO	Loose Teeth	___ YES ___NO
Headaches or Migraines	___YES ___NO	Sensitive teeth	___ YES ___NO
Bad Breath	___YES ___NO	Problems with Novacaine	___ YES ___NO

7. Do you have removable dentures or partial dentures? ___YES ___NO
   If yes, are you satisfied with the performance? _____
8. Do you use (**please circle**): Water Pic, Electric toothbrush, Fluoride, Mouthwash
9. Are you interested in whiter teeth? ___YES ___NO
10. Are you satisfied with the appearance of you smile? ___YES ___NO
11. Have you ever been dissatisfied with a dental treatment? ___YES ___NO
    If yes, please describe: _____
    _____
12. Would you like to change anything about your teeth?
    _____

RESPONSIBLE PARTY INFORMATION

The following is for: ___The patient ___The person responsible for payment

Name: _____
___Male ___Female ___Married ___Single ___Child ___Other

Social Security #: _____ Birth Date: _____

Phone (Home):_____Work_____ Cell_____

Address: _____Apt#_____

_____
City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ___The patient ___The person responsible for payment

Employer Name: _____Occupation_____

Address _____
Street City State Zip Code

INSURANCE INFORMATION

Name of Insured: _____ is insured a patient? ___YES ___NO

Birthdate: _____ Social Security #: _____

Address (If different from patient's) _____ Phone #_____

City_____ State_____ Zip Code_____

Employer name and address: _____

Occupation: _____Employer Phone #: _____

Name and address of Insurance Company: _____

Insured's ID #: _____ Group #:_____

Patient's relationship to Insured: ___Self ____Spouse ____Child ____Other

ADDITIONAL INSURANCE

Is patient covered by a Secondary Insurance Plan? ___YES ___NO

Subscriber Name: _____ Phone #: _____

Birthdates: _____ Social Security #: _____

Address: (If different from patient's) _____

City_____ State _____ Zip Code_____

Subscriber employed by: _____ Employer Phone #: _____

Name and address of Insurance Company: _____

_____

Subscriber's ID#: _____Group #: _____

AUTHORIZATION AND ASSIGNMENT

I certify that I, and/or my dependent(s) have insurance coverage with:

_____ _____

Name of Insurance Company

And assign directly to **Dr. Hunter Charvet and/or CHARVET DENTAL CENTER LLC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that **I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company and/or Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Please Print Name **Relationship to Patient**

Payment is due at time of treatment unless prior arrangements have been made.

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