Inspire Dental Group Patient Information

PATIENT INFORMATION

Date: _____

Name: _____ Date of Birth: (mm/dd/yyyy) _____

Nickname: _____ Gender (circle one): M F

Address: _____ Social Security Number: _____

_____ Home Phone: _____

City: _____ Cell Phone: _____

State: _____ Zip: _____ Relation to Insured: _____

email: _____

PATIENT EMPLOYER INFORMATION

Employer: _____ Phone: _____

Employer Address: _____

City, State, Zip: _____

ADDITIONAL INFORMATION

Closest Relative NOT living with you: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

I was referred to Inspire Dental Group by: _____

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INSURANCE INFORMATION- Complete for Primary Dental Insurance (and secondary, if applicable)

PRIMARY

Company Name: _____ Phone: _____

Address: _____ Policy/ Group Number: _____

_____

Insured's Name: _____ Relation: _____

Insured's SSN/ ID #: _____ Date of Birth: (mm/dd/yyyy) _____

Insured's Employer: _____ Phone: _____

Insured's Employer Address: _____

City, State, Zip: _____

SECONDARY

Company Name: _____ Phone: _____

Address: _____ Policy/ Group Number: _____

_____

Insured's Name: _____ Relation: _____

Insured's SSN/ ID #: _____ Date of Birth: (mm/dd/yyyy) _____

Insured's Employer: _____ Phone: _____

Insured's Employer Address: _____

City, State, Zip: _____

MEDICAL INSURANCE

Company Name: _____ Phone: _____

Address: _____ Policy/ Group Number: _____

_____

Insured's Name: _____

Insured's Employer: _____

Insured's Employer Address: _____ Phone: _____

City, State, Zip: _____

Inspire Dental Group Patient Information

Patient's Name: _____ Date of Birth: _____

_____
Name of person completing form (if different from patient) and legal relationship to patient

PLEASE ANSWER BY CIRCLING YES or NO

- Are you in good health? ..... YES NO
- Has there been any change in your general health in the past year? ..... YES NO
- Are you currently under a physician's care? ..... YES NO
  If so, what for? _____
- Physician's Name: _____
  Phone #: _____Fax #: _____
- Have you had any serious illness, operation or hospitalization? ..... YES NO
  If so, please describe: _____
- Have you ever had intravenous sedation or general anesthesia? ..... YES NO
- Any disease, drug or transplant operation that has depressed your immune system ..... YES NO
- Do you currently use any tobacco products? ..... YES NO

DO YOU HAVE OR HAVE YOU EVER HAD: (please check boxes)

Heart Disease
- ☐ Heart Attack
- ☐ Angina
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Bypass Graft
- ☐ Congenital Heart Disease
- ☐ Pacemaker
- ☐ Valve Replacement
- ☐ Rheumatic Fever

Abnormal Blood Pressure
- ☐ High
- ☐ Low
- ☐ Fainting spells
- ☐ Stroke

Skeletal Problems
- ☐ Joint replacement
- ☐ Fracture
- ☐ Plates and screws
- ☐ Osteoporosis

Blood Disorders
- ☐ Anemia
- ☐ Sickle Cell
- ☐ Hemophilia
- ☐ Abnormal bleeding
- ☐ Leukemia
- ☐ Other_____
- ☐ Recent INR _____

Diabetes
- ☐ Insulin dependent
- ☐ Non-insulin dependent
- ☐ Controlled
- ☐ Uncontrolled
- ☐ HbA1c _____

Arthritis
- ☐ Connective tissue disease
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Psoriasis

Lung Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Tuberculosis

Cancer
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Surgery
- ☐ Date_____
- ☐ Type_____

Other
- ☐ Depression
- ☐ Thyroid disease
- ☐ Alcoholism
- ☐ Seizure disorder
- ☐ Ulcers
- ☐ Glaucoma
- ☐ Herpes
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ HPV
- ☐ Kidney disease
- ☐ Venereal disease

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MEDICATIONS/DRUGS (please check boxes):

- ☐ Anticoagulants (blood thinners)
- ☐ Thyroid medications
- ☐ Bisphosphonates (for Osteoporosis)
- ☐ High blood pressure medications
- ☐ Heart medications
- ☐ Cholesterol reducing drugs
- ☐ Steroids
- ☐ Mood stabilizing drugs
- ☐ Recreational drugs
- ☐ Aspirin, Ibuprofen, NSAIDS
- ☐ Arthritis medications
- ☐ Narcotics
- ☐ Antidepressants, tranquilizers

PLEASE LIST ALL CURRENT MEDICATIONS: _____

_____

_____

Do you have any serious allergies, if so please list:

_____

Do you have any other disease, condition or problem not listed above that the doctor should know about or do you wish to talk to the doctor privately about anything?

_____

_____

WOMEN (please check boxes):

- ☐ Are you pregnant, trying to become pregnant?
- ☐ Are you taking birth control pills?
- ☐ Are you breast feeding?
- ☐ Are you taking hormone replacement therapy?

PHARMACY INFORMATION

Name: _____

Address: _____

Phone: _____

I understand the importance of a truthful health history and realize that incomplete information may have a serious adverse effect on my health and treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____

Signature Today's Date

_____

Print Full Name

Inspire Dental Group Patient Information

Welcome to Inspire Dental Group! We are committed to providing superior patient care in a friendly and nurturing environment. At Inspire Dental Group, we realize that every person's financial situation is unique and we have worked very hard to provide a variety of payment options to help you receive the dental care you need to enjoy a healthy and confident smile.

Dental Insurance

We will file any and all forms necessary to see that you receive the full benefits of your coverage. You will be expected to pay your portion on the day of service. Any balances not paid by the insurance company become the patient's responsibility to pay at that time.

Payment Options

- ☑ Credit Card - For your convenience, we have made arrangements to accept payment by several major credit cards as well as bank debit cards
- ☑ Long Term-Interest Free Financing - Applications are available and can be quickly processed while you are in the office
- ☑ Payment Plan - If multiple appointments are required you may divide half of your payment at the start of treatment and the balance upon completion, or setup a recurring credit card charge

Financial Responsibility

- ☑ Co-pays are due at time of service
- ☑ There is a $35 charge for all returned checks
- ☑ There is a $50.00 charge for broken/cancelled non-surgical appointments and a $100 fee for surgical appointments when not allowing a 24-hour notice
- ☑ Provider reserves the right to charge a collection fee of 30% of the principal balance at the time of write off or dismissal to a third-party collection agency.

Consent

I authorize the doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I will be given the opportunity to discuss my treatment plan and make financial arrangements before treatment is begun. If care is being rendered on a minor child, I authorize the doctor to obtain x-rays and to treat my child as needed. I understand that I will be given the opportunity to discuss the treatment with the doctor and that the parent or guardian who accompanies the child to the office is responsible for payment. Because there is growing evidence as to a periodontal systemic link which increases the risk of heart disease, stroke, uncontrolled diabetes, low birth weight babies and early term pregnancies and because treating periodontal disease has the potential to improve health and possibly even save lives, I am aware that Inspire Dental Group will notify my primary care physician as to my condition if appropriate.

I authorize Inspire Dental Group to discuss my treatment and any financial related matters with the following individuals:

Print Full Name _____ Relationship _____

Print Full Name _____ Relationship _____

My signature will authorize assignment of insurance benefits to this office. I acknowledge that I have been provided with a copy of the privacy policy of this office.

Signature _____ Today's Date _____

Print Full Name _____