BONAVENTURE
DENTAL CARE

PATIENT INFORMATION

Date
Last Name
First Name Middle
Sex: Marital Status:
Date of Birth
SSN
Address
City
State Zip Code
E-mail
Phone # Cell #
Contact preference:
Employer/School
Occupation
Employer/School Address
Employer/School Phone
Spouse Name
Spouse Date of Birth
Spouse SS#
Spouse Employer
Who may we thank for referring you?

DENTAL INSURANCE

Who is responsible for this account?
Do you have insurance?
Primary Insurance
Group # / ID#

Subscriber's Name
Date of Birth
Secondary Insurance
Group # / ID #

ASSIGNMENT AND RELEASE

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

Name of Insurance Company(s) and assign directly to

Dr. 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(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Printed name of Patient, Parent, Guardian, or Personal Representative

Date Relationship to Patient

DENTAL HISTORY

Reason for today's visit
Former Dentist
City/State
Date of last dental visit
Date of last dental X-rays

Click "Yes" or "No" to indicate if you have had any of the following:

Bad Breath ☐ Yes ☐ No
Bleeding/Swollen gums ☐ Yes ☐ No
Blister on lips or mouth ☐ Yes ☐ No
Burning sensation on tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No
Smoke: per day_____ ☐ Yes ☐ No
Other Tobacco Use_____ ☐ Yes ☐ No
Dry mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between teeth ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Jaw pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Mouth pain, brushing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Partial/Full Denture ☐ Yes ☐ No
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Mouth sores or growths ☐ Yes ☐ No

How often do you floss?
How often do you brush?

HEALTH HISTORY

Physician's Name _____ Phone Number _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

Have you ever taken any of the group of drugs referred to as "fen-phen (weight loss drug)?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine) and Redux (defenfluramine). ☐ Yes ☐ No

Check "Yes" or "No" to indicate if you have had any of the following:

*Artificial Heart Valves ☐ Yes ☐ No
*Damaged Heart Valves ☐ Yes ☐ No
*Heart Attack ☐ Yes ☐ No
If yes, date: _____
*Heart Murmur ☐ Yes ☐ No
*Rheumatic Fever ☐ Yes ☐ No
*Mitral Valve Prolapse ☐ Yes ☐ No
Angina ☐ Yes ☐ No
If yes, Stable or Unstable
Cardiovascular Disease ☐ Yes ☐ No
Congest. Heart Failure ☐ Yes ☐ No
Coronary Art.Disease ☐ Yes ☐ No
High or Low Blood Pressure (circle) ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Swollen Feet or Ankles ☐ Yes ☐ No
Arteriosclerosis ☐ Yes ☐ No
Bleeding Abnormally ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No
Blood Transfusion If yes, date: ☐ Yes ☐ No _____
Coumadin/Warfarin ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No

*Artificial Joint(s) ☐ Yes ☐ No
If yes, date: _____
Osteoporosis ☐ Yes ☐ No
Arthritis, Rheumatism ☐ Yes ☐ No
Back Problems ☐ Yes ☐ No
Acid Reflux/Ulcers ☐ Yes ☐ No
Hepatitis Type _____ ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
AIDS/HIV ☐ Yes ☐ No
Autoimmune Disease ☐ Yes ☐ No
Herpes ☐ Yes ☐ No
Recurrent Infections ☐ Yes ☐ No
If yes, specify: _____
Systemic Lupus Erythematosus ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
If yes, specify:
Venereal Disease ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Mental Health Disorders ☐ Yes ☐ No
If yes, specify: _____
Neurological Disorders ☐ Yes ☐ No
Seizures ☐ Yes ☐ No

Diabetes Type I or II ☐ Yes ☐ No
Eating Disorder ☐ Yes ☐ No
Special Diet ☐ Yes ☐ No
Unexplained Weight Loss ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Respiratory Disease ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Chemotherapy/ Radiation Treatment ☐ Yes ☐ No
If yes, specify: _____
Cortisone Treatments ☐ Yes ☐ No
Tumor/Cancer ☐ Yes ☐ No
Muscular Sclerosis ☐ Yes ☐ No
Alcohol Dependency ☐ Yes ☐ No
Controlled Substance Dependency ☐ Yes ☐ No
Fainting or dizziness ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
If yes: _____
Swollen Neck Glands ☐ Yes ☐ No
Other Not Listed: _____

MEDICATIONS

Please list any and all prescriptions or over-the-counter medicines you are taking and what the drug is treating:

_____
_____
_____
_____

ALLERGIES

Anesthetic ☐ Yes ☐ No
Aspirin ☐ Yes ☐ No
Barbiturates ☐ Yes ☐ No
Codeine ☐ Yes ☐ No
Epinephrine ☐ Yes ☐ No
Other(s) ☐ Yes ☐ No
Iodine ☐ Yes ☐ No
Latex ☐ Yes ☐ No
Metals ☐ Yes ☐ No
Penicillin ☐ Yes ☐ No
Sulfa ☐ Yes ☐ No
If yes, please specify: _____

EMERGENCY CONTACT

IN CASE OF EMERGENCY, CONTACT (Specify someone who does **not** live in your household.)

Name _____ Relationship _____
Home Phone _____ Work Phone _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and the information given on this form is accurate. I understand the importance of a truthful health history and my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

CANCELLATION POLICY: I understand I am required to give the office 24 hours notice when canceling an appointment as this time is reserved or there will be a $25 fee charged which I am responsible for.

_____ _____
Signature Date

BONAVENTURE
DENTAL CARE

PAYMENT POLICY

INSURANCE: We will assist you with acquiring your insurance benefits by filing your claim for each date of service treatment is performed. You must supply us with all necessary forms, information and policy numbers. We do this as a courtesy to you.

LEGAL CASES: We do not treat patients on a contingency bases: payment is due when treatment is rendered, even where legal cases are pending settlement.

FINANCIAL CHARGES: Any unpaid balance that is 90 days overdue will assume a 1.5% finance charge per month until balance is paid. A collections agency will be contracted if we are unable to collect the balance which does reflect on your credit report.

ACKNOWLEDGEMENT

PAYMENT RESPONSIBILITY: I, _____, agree to assume full financial responsibility for my bills with Bonaventure Dental, its doctors and/or entities in the event my insurance does not pay. I assume responsibility for understanding the terms of MY insurance policy. I understand I am responsible for obtaining authorization referrals from my primary care physician or insurance company if such is required under MY insurance policy.

Patient Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

I WILL BE PAYING BY ____ CASH ____ CHECK ____ CREDIT CARD ____ CARE CREDIT