Patient Information

Patient's First Name	Middle Initial	Last Name (as it appears on insurance card or ID)	☐ Male ☐ Female
Preferred Name (if any)	Date of Birth	Social Security Number	
Patient's Address	City	State	Zip
Home Phone	Cellular	Email Address	
Referred By			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance Information

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name (as it appears on Insurance card or ID)		Relation to Patient	Insured's phone number
Insured's Address		City	State	Zip
Insured's Social Security Number		Insured's Birth date	

Financial Responsible Party

Billing Name (If other than patient)	Relation to Patient	Phone	
Address	City	State	Zip

Medical History - Your Physician Name/Phone Number: Dr.

Do you have or have you ever had any of the following?

☐ AIDS/HIV	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Alzheimer's Disease	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anaphylaxis	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Anemia	☐ Cortisone medicine	☐ Heart Attach/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Sinus Trouble
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolepses	☐ Spina Bifida
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joint	☐ Stroke
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Swelling of Limbs
☐ Breathing Problems	☐ Excessive Thirsty	☐ Herpes	☐ Psychiatric Care	☐ Thyroid Disease
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Therapy	☐ Tonsillitis
☐ Cancer or Tumor	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tuberculosis
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
☐ Chest Pain	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever	☐ Venereal Disease

Comments: (Any other illness not listed above?)

Current Medications

Are you taking any blood thinner? ☐ Yes ☐ No

If yes, please name it: _____

Are you taking **Osteoporosis** Medication? ☐ Yes ☐ No

If yes, please name it: _____

Hospitalizations & Surgeries? ☐ Yes ☐ No

If yes, please list Date & Reason.

Have you ever Smoked? ☐ Yes ☐ No # of years _____

Do you use recreational drugs? ☐ Yes ☐ No Types? _____

How much alcohol do you drink per week? _____

Are you taking any medication? ☐ Yes ☐ No

If yes, please list medication.

Women Only Are you pregnant? ☐ Yes ☐ No Nursing? Yes ☐ No ☐ Birth Control? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Penicillin	☐ Latex	☐ Sulfa	☐ Local Anesthetics	☐ Codeine

Other

Dental History

Reason for visit Today : _____

When was your last dental exam? _____

How often do you brush? # per day _____

How often do you floss? _____

Do you grind or clench your teeth? ☐ Yes ☐ No

If yes, do you wear Night/Day Guards? ☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment? ☐ Yes ☐ No

Have you ever had periodontal (gum) treatment? ☐ Yes ☐ No

Do you have any of the following?

☑ Bad breath	☐ Difficulty Chewing	☐ Sensitivity to Cold/Hot
☑ Bleeding gums	☐ Ear Pain	☐ Partials
☑ Blisters on mouth	☐ Jaw Pain	☐ Sensitivity to Sweets
☐ Dentures	☐ Loose Teeth	☐ Mouth Sores
☐ Dry Mouth	☐ Mouth Plain	☐ Swollen Gums

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

Signature of Patient, parent or guardian Doctor Signature Date

Financial Policy

We are committed to providing the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing up-to-date information and educational tools so you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service while minimizing our administrative costs.

All charges incurred are your responsibility regardless of your insurance coverage. As your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company.

As a courtesy, we will process your dental claims with your primary insurance provider. In order for our office to file your insurance claim, you must provide complete and accurate dental insurance information. Any changes in dental insurance must be provided in order to process your claims.

Although benefits may be verified at the time of service, it is not a guarantee that your insurance company will cover our services. Please understand that financial responsibility for dental services rests between you and your dental plan. While we are pleased to be of service by filing your dental insurance for you, we are not responsible for any limitations in your plan coverage. If your plan denies payment for any reason or has not paid your claim within 60 days, you will be responsible for payment.

Our office accepts cash, checks, all major credit cards and Care Credit.

There is $25.00 fee for all returned checks.

Appointments missed without a 24-hour cancellation notice may incur a $25.00 fee. This fee must be paid in order to schedule any future appointments.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with a positive experience in our office.

By signing below, I confirm that I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any service performed by Bobcat Dental.

_____

Patient Signature / Print Name (If different from patient) / Date

Authorization for Communication

With my initials below, Bobcat Dental may use and disclose protected health information about me to carry out appointment, treatment and payment. Please refer to Bobcat Dental's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practice at any time.

With My Consent

Bobcat Dental may also send mail or email to my home in reference to any items that assist the practice in carrying out treatment, payment, and health care operations such as appointment reminders, billing information, insurance items, newsletters, contests, and promotions.

Please check the appropriate box below indicating your method of communication: (mark all that apply)

☐ Home Phone: _____ ☐ Work Phone: _____

☐ Cell Phone: _____ ☐ Email: _____

If you mark any phone, please check the appropriate box below:

☐ Leave a message on voice mail with detailed information

☐ Leave a message on voice mail with a call-back number only

If you mark home phone, please check the appropriate box below:

☐ Leave a message on answering machine and may leave a message with whomever answers my home phone

☐ Do not leave a message on answering machine or speak to anyone in my household other than myself.

I understand that any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment, and health care operations. I understand and have been provided a Notice of Patient Privacy handout that provides a more complete description of information uses and disclosures. A photocopy or fax of the consent is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

_____ _____

Signature of Patient or Parents/Guardian Date

_____

Print Name of Signed person (if patient is under the age of 18 years)

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that this organization from time to time and that I may request a current copy at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Please list family members or other persons, if any, whom we may inform about your general dental condition and your diagnosis (including appointment, treatment, & financial account).

I, (Patient)_____, received Notice of Privacy Practices, and do hereby consent to have information regarding my appointment, treatment & financial account discussed with/and or released to:

I, (Parent/Guardian)_____, received Notice of Privacy Practices, and do hereby consent to have information regarding patient's appointment, treatment & financial account discussed with/and or released to:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____

Signature of Patient or Parents/ Guardian Date