CONFIDENTIAL PATIENT INFORMATION – I

PERSONAL INFORMATION

Patient Name:_____Preferred Name:_____SS#:_____

Home Address: _____ Home Phone #:_____

_____, _____ _____ Cell#: _____

Business Address:_____ Business Phone #:_____

_____, _____ E-mail Address: _____

Occupation_____ Preferred Contact (home/cell/email):_____

Date of Birth:_____ Age:_____ Sex:_____ Marital Status:_____

How did you hear about us?_____ Who were you referred by? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____Relationship: _____ SS #:_____

Address: _____

Home Phone: _____Business Phone: _____

Name and phone number of nearest relative not living with you_____

DENTAL INSURANCE INFORMATION

Insurance Company _____ Group #_____

Ins. co.'s address _____Phone_____

Employee's name:_____ID/SS#: _____ DOB_____

Employer: _____ Your relationship to employee: _____

Please let us know if you have any additional dental insurance policies.

OFFICE FINANCIAL POLICY

Although we do not participate in any particular dental insurance plan, we gladly remove any burden by filing your claim for you. Payment is requested at the time of service for any balance not covered by insurance. Payment arrangements may be discussed prior to rendering treatment. Balances exceeding 60 day past due from date of treatment may incur a finance charge of 18% APR. Balances exceeding 90 days past due can initiate collection procedures. Additional court, attorney and collection fees will be assessed and become the patient's &/or responsible person's obligation. Your signature below indicates your understanding of our financial policy.

I understand the financial policy of this office and have provided true and accurate information.

I authorize payment of the dental benefits otherwise payable to me directly to the dentist for services rendered. In addition, I authorize this office to provide any insurance company, claim administrator, and consulting health care professionals, information concerning health care advice or treatment.

Signature:_____ Date: _____

Signature of Patient (Parent or Guardian if patient is under 18 years of age)

Maura B. Brungo, DMD and Ronald A. Brungo, DMD
100 Oakwood Avenue, Suite 200, State College, PA16803
814-237-4300

(OVER)

CONFIDENTIAL PATIENT INFORMATION – II

DENTAL HEALTH RECORD

Date of last dental exam: _____ Date of last x-rays: _____Former dentist: _____

Have you ever had any serious problem with dental treatment? _____ If so, please explain: _____

Do you gag easily?_____ Do you have pain or clicking in or near your ears?_____

Do your gums bleed when you brush or floss?_____ Do you clench or grind your teeth?_____

Do you have any concerns about receiving dental treatment?_____

Is there anything about your smile you want to change?_____

Circle any that you are interested in: ◯ Whitening? ◯ Implants? ◯ Crowns/Veneers? ◯ White fillings?

MEDICAL HEALTH RECORD

Family physician's name and phone number_____

Date of last physical examination_____

☐ YES NO ☐ 1. Are you presently under the care of a physician? If yes, for what? _____

☐ YES NO ☐ 2. Have you ever been hospitalized or had a serious illness? If yes, for what?_____

☐ YES NO ☐ 3.Are you currently taking or have ever taken any drug for osteoporosis? _____

☐ YES NO ☐ 4. Do you bleed excessively upon injury? _____

☐ YES NO ☐ 5. Do you smoke or use smokeless tobacco? _____

☐ YES NO ☐ 6. Are you taking <u>any</u> drug or medicine? If yes, what and what for? _____

_____

☐ YES NO ☐ 7. Are you currently pregnant? Are you currently nursing? _____

CIRCLE ANY CONDITIONS THAT YOU HAVE HAD

◯ **AIDS or HIV**	◯ **Diabetes**	◯ **High Blood Pressure**	◯ **Psychiatric Care**
◯ **Alcoholism**	◯ **Drug Abuse**	◯ **Jaundice**	◯ **Radiation Therapy**
◯ **Anemia**	◯ **Epilepsy**	◯ **Kidney Problems**	◯ **Rheumatic Fever**
◯ **Arthritis**	◯ **Glaucoma**	◯ **Low Blood Pressure**	◯ **STD**
◯ **Asthma**	◯ **Heart Murmur**	◯ **Artificial Joints**	◯ **Stroke**
◯ **Cancer**	◯ **Heart Problems**	◯ **Osteoporosis**	◯ **Tuberculosis**
◯ **Chemotherapy**	◯ **Hepatitis**	◯ **Pacemaker**	◯ **Other** _____

CIRCLE ANY ALLERGY THAT YOU MAY HAVE

◯ **Local Anesthetics**	☐ **Aspirin**	◯ **Jewelry/Metal**	◯ **Sedatives**
◯ **Antibiotics**	☐ **Codeine**	◯ **Latex**	◯ **Other**_____

EMERGENCY CONTACT PERSON

Name: _____ Address: _____

Home Phone: _____Business Phone: _____

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