Patient Information

Patient Name: _____ Date_____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell): _____

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Whom May We Thank for Referring You to our office? _____

Health History: **Date of Last Dental Visit: _____ Reason for today's visit: _____**

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

- ☐ AIDS/HIV Positive
- ☐ Allergies to Medications _____
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints Date of Surgery _____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer Type_____
- ☐ Dental Anxiety
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems/GERD
- ☐ Stroke
- ☐ Thyroid Condition (Hyper/Hypo) _ _____
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ HPV/STD

OTHER:
- ☐ _____
- ☐ _____

· Do you require antibiotic pre-medication for previous heart infections, heart defects you were born with, replacement heart valves, or joint replacements? _____

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

· Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

· Please list all medications or provide list: _____

· Have you ever taken or are you currently taking medication for osteoporosis (i.e. Fosamax, Boniva)? ☐ Yes ☐ No

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 at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

In case of emergency, please contact: Name: _____ Phone #:_____

Best Form of Communication for Appointment reminders

☐ Text Message_____ ☐ Email _____

Policy Holder or Responsible Party Information *MUST BE COMPLETED*

The following is for: ☐ the policy holder ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ **Birth Date**: _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____

Street Apartment #

_____

PRIMARY Dental Insurance Company: _____ **Phone Number** _____

Identification Number: _____ **Group or Plan Number:** _____

SECONDARY Dental Insurance Company: _____ **Phone Number:** _____

Identification Number: _____ **Group or Plan Number:** _____

Policy Holder Name _____ **Date of Birth:** _____

*******PLEASE NOTE WE ARE NOT PARTICIPATING WITH FEP BLUE, DELTA, METLIFE OR CIGNA*******

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients and insurance for the costs incurred in their care, and that the financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Larry G. Reyes DDS PLC, provides insurance company billing as a courtesy to our patients. The patient portion of particular dental services is estimated, and due at the time of service. This amount may be subject to an adjustment when the dental service(s) claim is finalized by the insurance company. In addition, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not fully rely upon any information provided by Larry G. Reyes, DDS PLC staff regarding his/her remaining benefit in any such benefit period.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

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

Relationship to Patient: _____