BLUESTONE DENTAL

INFORMATION SHEET

The following essential information is requested to eliminate potential accounting and/or insurance problems. Your cooperation in completing this form is greatly appreciated.

PATIENT INFORMATION (PLEASE PRINT)

NAME, LAST	FIRST	MIDDLE INITIAL	MAIDEN	BIRTHDATE / /	AGE	SEX
STREET ADDRESS		CITY		STATE	ZIP	
PHONE (HOME)	PHONE (CELL)		EMAIL			
S.S. NO.	MARITAL STATUS S M W D Sep		SCHOOL and grade if student			
OCCUPATION	EMPLOYER	EMPLOYER'S ADDRESS		PHONE (WORK)		
SPOUSE'S NAME	S.S. NO.	SPOUSE'S EMPLOYER		SPOUSE'S BIRTHDATE		

GUARANTOR INFORMATION (Person Financially Responsible)

NAME, LAST	FIRST	MIDDLE INITIAL	MAIDEN	BIRTHDATE / /	S.S. NO.
STREET ADDRESS	CITY	STATE	ZIP	PHONE	
EMPLOYER	EMPLOYER'S ADDRESS			PHONE	

RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

DENTAL COVERAGE INSURANCE NAME	SUBSCRIBER'S NAME	POLICY/AGREEMENT	GROUP NO.

If you have DOUBLE DENTAL INSURANCE coverage, complete this for the second coverage.

OTHER DENTAL COVERAGE ☐ YES ☐ NO	IF YES, OTHER INSURANCE NAME	SUBSCRIBER'S NAME	POLICY/AGREEMENT NO.	GROUP NO.

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME, LAST	FIRST	MIDDLE INITIAL	PHONE
STREET ADDRESS	CITY	STATE	ZIP

METHOD OF PAYMENT ☐ Cash ☐ Check ☐ Credit Card

How did you find out about our services?

☐ Bell Yellow Pages ☐ Donnelley Directory ☐ Other Patient ☐ Family Member ☐ Other _____

Who may we thanks for referring you? _____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

RESPONSIBILITY FOR DEBT: I understand that I am responsible for payment for services rendered or dental appliances received. I further understand that payment is due at the time services are rendered unless special arrangements are made PRIOR to treatment. In the event of default, I agree to pay reasonable attorney fees and other cost incurred in collection.

_____ DATE _____

Please sign the following: (For Insurance Purposes)

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize Bluestone Dental to release any information acquired during my examination or treatment.

_____ DATE _____

AUTHORIZATION OF BENEFITS: I hereby authorize payment directly to Bluestone Dental of benefits otherwise payable to me.

_____ Signature of Patient

_____ Signature of Subscriber

_____ Date

• PATIENT MEDICAL / DENTAL HISTORY •

It is important that I know about your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	**YES**	**NO**
HOW LONG SINCE you have seen a Dentist? _____		
Last COMPLETE EXAM DATE: _____		
Last FULL MOUTH X-RAYS DATE: _____ (16 small films or Pano.)		
Are you having PROBLEMS now?	☐	☐
WHAT? _____		
Is your present dental health poor?	☐	☐
Do you wear DENTURES? (Partial or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Do you use FLUORIDE RINSE?	☐	☐
What type of tooth brush: soft medium hard (circle)	☐	☐
Do you have BURNING TONGUE / Lips? (circle)	☐	☐
Do you have frequent BLISTERS, lips / mouth? (circle)	☐	☐
Do you have CLICKING / POPPING jaw?	☐	☐
Do you have difficulty opening or closing jaw?	☐	☐
Are you aware of change in bite, shifting teeth, food impaction? (circle)	☐	☐

How do you feel about your teeth?
Please RANK the following in the order in which they would PREVENT YOU FROM having dental treatment: (1 - Very Important, 2 - Important, 3 - Not Important)

FEAR of pain # _____ LACK of concern # _____

COST of treatment # _____ MISSING work time # _____

• MEDICAL HISTORY •

Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐

For what? _____

What MEDICATIONS are you currently taking? _____

_____

For What? _____

Are you PREGNANT?	☐	☐
Do you SMOKE?	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Mitral Valve Prolapse
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Artificial Joints (hip, knee, pins, plates)
Anemia
Stroke
Kidney Trouble
Ulcers
A.I.D.S. / A.R.C. / H.I.V.
Hepatitis A (infectious)
Hepatitis B (serum)
Liver Disease
Blood Transfusion
Drug Addiction
Hemophilia (Bleeding problem)
Fever Blisters
Epilepsy or Seizures
Nervousness
Psychiatric Treatment
Glaucoma
Chemotherapy (Cancer, Leukemia)
Venereal Disease (Syphilis, Gonorrhea, etc.)
Bruise Easily
Emphysema
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes
Thyroid Disease
Radiation Treatment
Arthritis
Cortisone Medicine
Pain in Jaw Joints
Alcoholism
Cosmetic Surgery

	YES	NO
HAS YOUR PHYSICIAN DIRECTED you to TAKE or to STOP taking any MEDICATION PRIOR TO DENTAL APPOINTMENT?	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Penicillin	Sulfa Drugs	Nitrous Oxide
Codeine	Erythromycin	Sedatives/Barbiturates
Aspirin	Local Anesthetics	Darvon

Are you aware of being allergic to any other medicines or substances (i.e., Latex).	☐	☐

If yes, list: _____

Is there any other medical or dental information that you feel I should hear about?.	☐	☐

FAMILY PHYSICIAN _____ PHONE NO. _____

PLEASE SIGN BELOW:

1. TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR IN MY MEDICATION, I WILL INFORM THE DENTIST AT THE NEXT APPOINTMENT.

_____ DATE _____

*** PLEASE STATE CLEARLY THE REASON FOR THIS 1ST VISIT TO OUR OFFICE.** _____

_____

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