PATIENT'S INFORMATION
(Confidential)

Please Print Clearly and Complete All Entries

PATIENT'S NAME: ____ BIRTHDATE:__________________

ADDRESS:____
(STREET APT# CITY STATE ZIP)

HOME#:_____________________ CELL#:___________________ WORK &EXT#:_______________________

SS#:____________________________________ DRIVER'S LICENSE#:____________________________

EMPLOYER:____ OCCUPATION ___________________

ADDRESS:____
(STREET SUITE# CITY STATE ZIP)

DENTAL INSURANCE: Yes___ No___ Policy Holders Name/Relationship:_____________________________

EMERGENCY NOTIFY __________________________ HOME#:_______________ CELL#:_______________
(OTHER THAN SPOUSE)

STUDENT: YES_____ NO_____ SCHOOL ATTENDING:____

_____ Please Check if you are <u>NOT</u> financially responsible for your account. <u>If checked, please fill out information below.</u>

Patients that are not financially responsible for themselves, please fill out the <u>RESPONSIBLE PARTY</u> information below.

NAME: ____ BIRTHDATE:______________________

RELATIONSHIP TO PATIENT:____

(H) ADDRESS:____
(STREET APT# CITY STATE ZIP)

HOME#:_____________________ CELL#:___________________ WORK &EXT#:_______________________

SS#:____________________________________ DRIVER'S LICENSE#:________________________________

EMPLOYER:____ OCCUPATION ___________________

(W) ADDRESS:____
(STREET SUITE# CITY STATE ZIP)

(Please carefully read all information below and sign)

<u>PAYMENT FOR SERVICES</u>

I understand as the patient or responsible party of the said patient, that I am responsible for all charges for services on the date services are rendered. Even if insurance is provided, I also understand that I am responsible for payment of any deductibles, percents, or past due balances at this time.

I understand a 24-hour notice of cancellation is required prior to my or my dependent's appointment. If no notice is given I will be charged $30.00 for the broken appointment.

I understand I will be charged a $35.00 fee for any checks returned for non-sufficient funds. I also understand that if a collection agency is used to recover any charges for my account or my dependents account, I will assume the fee for such agency to be used and the fee will be billed to my account.

Patient's Name:_______________________________________ Relationship to Patient:___________________

Signature:____ Date:__________________________
(Signature of Patient or Person Financially Responsible)

MEDICAL INFORMATION

PHARMACY:_______________________ LOCATION:________________ PHONE#:__________________

PHYSICIAN:____ PHONE#:_________________

Yes No

___ ___INFECTIVE ENDO CARDITIS
___ ___HIGH BLOOD PRESSURE
___ ___ARTIFICIAL HEART VALVES
___ ___PACEMAKER/DEFIBRILLATOR
___ ___HEART MURMUR
___ ___SCARLET FEVER
___ ___RHEUMATIC FEVER
___ ___MITRAL VALVE PROLAPSE
___ ___DIABETES
___ ___KIDNEY DISEASE
___ ___LIVER DISEASE
___ ___HEPATISTIS/Type______________
___ ___BLOOD DISEASE
___ ___HEMOPHILLIA
___ ___AMEMIA
___ ___HIV POSITIVE/AIDS
___ ___MRSA

Yes No

___ ___STROKE
___ ___ EPILEPSY/SEIZURES
___ ___ GLAUCOMA
___ ___FAINTING/DIZZINES
___ ___ARTHRITIS/Type________________
___ ___CIRCULATORY PROBLEMS
___ ___TUBERCULOSIS
___ ___RESPIRATORY DISEASE/COPD
___ ___ASTHMA
___ ___PERSISTENT COUGH
___ ___SMOKE/OTHER TABACCO
___ ___SINUS TROUBLE
___ ___INNER EAR PROBLEM
___ ___HEADACHES/MIGRAINES
___ ___REFLUX DISEASE/GERD
___ ___LUPUS/AUTO IMMUNE
___ ___

Yes No

___ ___THYROID
___ ___SPLEENECTOMY
___ ___HEARING PROBLEM
___ ___ALZHEIMER/DEMENTIA
___ ___CANCER/Type___________
___ ___CHEMOTHERAPY
___ ___RADIATION TREATMEN

Have You Taken Any of the Following Medications:

___ ___IV / BISPHOSPHONATES
Reclast, Pamidronate, Zoledronic Acid, or Aredia
___ ___OSTEOPOROSIS

Have You Taken Any of the Following Medications:

___ ___Fosamax, Actonel, Boniva, Forteo, Evista, Didronel, or Skelid
___ ___ALLERGY: Latex/Rubber
___ ___ALLERGY: Metals ____
____

Yes No

___ ___ORGAN TRANSPLANT LIST & DATES: ____
___ ___IMPLANTS LIST & DATES:____
___ ___ARTIFICIAL JOINTS LIST & DATES:____
___ ___PREMEDICATION NEEDED:_______________________ PRESCRIPTION:_______________________
___ ___ARE YOU TAKING MEDICATIONS / PLEASE LIST / or / WE WILL COPY YOUR LIST:____________________
____
___ ___ARE YOU ALLERGIC TO MEDICATIONS LIST:____
___ ___ARE YOU SENSITIVE TO MEDICATIONS LIST:____
___ ___(WOMEN) PREGNANT OR TRYING TO CONCEIVE IF YES, DUE DATE:____________________________

I authorize Scharfenberger Family Dentistry, P.S.C. / Dr. D. Ed Scharfenberger, Jr. and Associates to release any information including diagnosis and the records of any treatments or examination rendered to my dependents or myself during the period of such dental care, to third party payers and / or / other health care practitioners.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:____ Date:__________________________

(Signature of Patient or Responsible Person)