PORTEOUS FAMILY DENTISTRY

Larry Porteous D.D.S & Linda Porteous R.D.H.

Welcome to our office

PATIENT INFORMATION

Please read and fill out these forms completely, it is important for your dental care and will help us achieve our goal to help you reach and maintain good oral health and to provide you with the best possible dental experience in our office. Thank- you

TODAY'S DATE: _____

Patient Name: Last_____ First _____M.I.____

Address: Street _____ City _____ State _____Zip_____

Hm. Phone #: ( ) _____Cell Phone #: ( ) _____

Birth Date: _____ Male: ____ Female: ____ Preferred Name:_____

S.S. # _____ Drivers License # _____

E-Mail: _____ Marital Status: _____

Employer: _____ Work Phone #: ( ) _____

Address: Street_____ City _____ State _____ Zip _____

Occupation: _____If Student- College Attending:_____

Spouse's Name or Parent (if patient is a minor):_____

How do you prefer that we contact you? _____

Can we leave messages for you regarding your dental treatment/appointments? _____

Person to contact in case of an emergency: _____

Relationship: _____ Phone #: ( ) _____

Who can we thank for referring you to our office? _____

What is the purpose of your visit today? _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

I consent to treatment as necessary or desirable to the care of the patient named above, including but not limited to whatever drugs, medicines, performance of operations and conduct of laboratory, x-ray, laser treatment or any other procedures that may be used by Porteous Family Dentistry, including any attending dentist or qualified designate:

Signature of Patient or Parent/ Guardian (if patient is under 18 yrs. of age):

_____ Date:_____

ACCOUNT AND INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT:

Name: Last _____ First _____

Address: Street_____ City _____ State _____ Zip_____

Relationship to Patient: _____ Phone # ( ) _____

PRIMARY DENTAL INSURANCE:

Policy Holder Name: Last _____ First _____ Birth date: _____

Address: Street _____ City _____ State _____ Zip _____

Insurance Company Name: _____ Phone # ( ) _____

Insurance Company Address: _____

Policy Holder S.S. #: _____ Insurance I D # (if one) _____

Group #: _____

SECONDARY DENTAL INSURANCE:

Policy Holder Name: Last _____ First _____ Birth date: _____

Address: Street _____ City _____ State _____ Zip _____

Insurance Company Name: _____ Phone # ( ) _____

Insurance Company Address: _____

Policy Holder S.S. #: _____ Insurance I D # (if one) _____

Group #: _____

AUTHORIZATIONS AND ACKNOWLEGEMENTS

- I hereby acknowledge full responsibility for the payment of dental services and agree to pay them in full at the time of service, unless other arrangements are made with this office or are to be paid by my Insurance Company.
- I hereby authorize assignment of my insurance benefits to Dr. Lawrence Porteous for dental services rendered and authorize the release of any information necessary to secure the payment of benefits.
- I understand that this office will bill my insurance company as a courtesy to me. Porteous Family Dentistry is not responsible for my insurance company making timely and accurate payment. Any services not paid by my insurance company will by my responsibility including any co-payment and deductions. Any balance is due in full after 60 days of service.
- Accounts are due 15 days from the date of statement. If not received, balance will be subject to a monthly finance charge computed by a Periodic Rate of 11/2% = Annual Percentage Rate of 18%. Should suit be necessary to collect, reasonable attorney fees, plus costs shall be awarded in addition to the principal due.

I have read and understand the above:

Signature of Patient/Responsible party:_____ Date:_____

DENTAL HISTORY

Patient Name: _____ Birth Date: _____ Today's Date: _____
Purpose of today's visit: _____ Date of last dental visit: _____
Name of previous Dentist: _____ City: _____ Phone #: _____
How often do you brush? _____ floss? _____ Do your gums bleed? _____
Are you currently in pain? YES NO Where? _____

Were you ever instructed by a professional in proper dental care (oral hygiene)? YES NO
Do you smoke or use Tobacco in other forms? YES NO
Do you wear removable dental appliances, partials or dentures? YES NO
Are you worried about receiving dental treatment? YES NO
Explain: _____
Are you dissatisfied about the appearance of your teeth? YES NO
Explain: _____
Do you have any conditions in your mouth that concern you? YES NO
Explain: _____
Have you ever had complications associated with any previous dental treatment? YES NO
Explain: _____
Have you ever had injury, surgery or radiation treatment to your head, neck or jaw? YES NO
Explain: _____
Why did you leave your previous dentist? _____
What did you like most or least about any dentist you have seen? _____
_____

MEDICAL HISTORY

Date of last medical exam: _____ Rate your general health (1-Excellent to 10-Poor) _____
Physician Name: _____ City: _____ Phone #: _____

Are you currently under the care of your Physician? YES NO
Explain: _____
Have there been any changes to your health within the last year? YES NO
Explain: _____
Have you been hospitalized or had a serious illness or injury in the last 3 years? YES NO
Explain: _____

What medications are you currently taking and why? _____

Are you allergic to any of the following: CIRCLE: Aspirin Tylenol Ibuprofen Codeine Vicodin
Penicillin/Amoxicillin Erythomycin Clindamycin Tetracycline Sulfa Drugs Dental Anesthetics
Sedatives jewelry/metals Latex OTHERS: _____

WOMAN: Are you pregnant? YES NO

OVER

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING DISEASES, MEDICAL CONDITIONS OR PROCEDURES? CIRCLE: YES OR NO

Y	N	Abnormal Bleeding	Y	N	Depression	Y	N	Herpes
Y	N	Alcohol Abuse	Y	N	Diabetes	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	Difficulty breathing	Y	N	HIV/AIDS
Y	N	Angina/chest pain	Y	N	Drug Abuse	Y	N	Kidney Problems
Y	N	Anxiety	Y	N	Emphysema	Y	N	Liver Problems
Y	N	Arthritis/Rheumatism	Y	N	Epilepsy/Seizures	Y	N	Low Blood Pressure
Y	N	Artificial Joints	Y	N	Fainting spells	Y	N	Psychiatric Problems
Y	N	Artificial Heart Valves	Y	N	Fever blisters	Y	N	Respiratory Problems
Y	N	Asthma	Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Back/neck Problems	Y	N	Headaches frequent/severe	Y	N	Stomach Problems/Ulcers
Y	N	Blood Transfusion	Y	N	Heart Attack	Y	N	Stroke
Y	N	Cancer/Tumors	Y	N	Heart Disease	Y	N	Thyroid Problems
Y	N	Chemotherapy	Y	N	Heart Surgery	Y	N	Tuberculosis
Y	N	Congenital Heart Defects	Y	N	Hepatitis A B C	Y	N	Venereal Diseases
			Y	N	Heart Murmur	Y	N	X-ray/Radiation Treatment

Anything else you would like to report regarding your Heath: _____

- In rare cases, patients may experience unusual reactions to dental treatment, materials or local anesthetics.
- Antibiotics and possibly other medications may reduce the effectiveness of oral contraceptives.
- This office charges for failure to cancel appointments without giving 2 days (48 hrs.) notice or to simply "No Show". A charge of $50.00 per hr. of appointment time missed will be applied to your account.

I understand the above and I affirm that the information I have provided is correct to the best of my knowledge and understand that it is my responsibility to inform this office of any changes

Signature: _____ Date: _____
(Patient or Parent / Guardian if under the age of 18)

OFFICE USE ONLY: UPDATE

DATE: _____ INITIAL: _____ COMMENTS: _____
DATE: _____ INITIAL: _____ COMMENTS: _____
DATE: _____ INITIAL: _____ COMMENTS: _____
DATE: _____ INITIAL: _____ COMMENTS: _____