Patient Information

First Name________________________Initial_____
Last Name__________________________________
Address____________________________________
City____________________________State_______
Home Phone (___) ____________________________
Cell Phone (___) _____________________________
Email ______________________________________
Birthday ______________ SS# _________________
Emergency Contact__________________________

Relationship________________________________
Home Phone (___) ___________________________
Cell Phone (___) _____________________________

Marital Status (circle one)
Single/Married/Divorced/Widowed
Spouse_____________________________________
Home Phone (___) ___________________________
Cell Phone (___) _____________________________

Employment Information

Primary Policy Holder

First Name________________________Initial_____
Last Name__________________________________
Birthday ______________ SS# _________________
DL#____________________________State_______
Employer___________________________________
Address____________________________________
City____________________________State_______
Work Phone_________________________________

Secondary Policy Holder

First Name________________________Initial_____
Last Name__________________________________
Birthday ______________ SS# _________________
DL#____________________________State_______
Employer___________________________________
Address____________________________________
City____________________________State_______
Work Phone_________________________________

Dental Insurance Information

Primary Policy Holder

Insurance Company__________________________
Address____________________________________
City_____________________State_____Zip_______
Insurance Phone_____________________________
Plan Name__________________________________
Group # ____________________________________
Relationship to patient______________________

Primary Policy Holder

Insurance Company__________________________
Address____________________________________
City_____________________State_____Zip_______
Insurance Phone_____________________________
Plan Name__________________________________
Group # ____________________________________
Relationship to patient______________________

Authorization

I hereby authorize payment directly to Andrew P. Achord, DMD, PA insurance benefits otherwise payable to me. I authorize the administration of such medications and diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I grant the right to Andrew P. Achord, DMD, PA to release my medical/dental histories and other information about my dental treatment to third party payors and/or other health professionals. The information on this page is correct to the best of my knowledge.

Patient or Responsible Party_____________________________________ **Date**___________________

Financial Policy

Andrew P Achord, DMD, PA

I understand that Andrew P Achord, DMD PA is a fee-for-service practice and all fees are due and payable at the time of service. We accept cash, check, credit card, and Care Credit® financing. I understand that a service fee may be assessed on any past due accounts and an INTEREST RATE OF 18% PER MONTH may be assessed on any accounts greater than 90 days past due. This will apply to all account balances including those that exist when insurance companies delay making payment. I understand that I am responsible for all fees INCLUDING those that insurance doesn't pay. In case of default of payment, I promise to pay any interest on the total balance and any collection costs and attorney fees incurred while trying to collect the balance of my account. I also understand there will be a $25 service charge on all returned checks.

Patient or Responsible Party____________________________________ **Date**___________________
(Please Print)

Patient or Responsible Party____________________________________ **Date**___________________

Billing Information

If different from the address on the first page- this is **not** your insurance information.

How will you be paying for services rendered? (please circle one)

CASH / CHECK/ CREDIT CARD / CARE CREDIT

Any remaining balance billed to the attention of: ____
Address________________________________City___________________State______Zip__________
Phone_________________________________

Patient or Responsible Party____________________________________ **Date**___________________

Dental Health History

When was your last dental Exam? _________________ Most recent dental X-Ray?_______________________

Most recent dental treatment? ___________________ Routine dental exams? Yes / No

How often do you have your teeth cleaned? *(circle one)* Every 3, 4 , 6 months or longer.

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

Have you ever required premedication prior to any dental appointment in the past? ___________________

Do you now, or have you had in the past, dental anxiety?	YES	NO
Have you had unfavorable dental experiences in the past?	YES	NO
Have you ever had an unfavorable reaction to dental anesthetic?	YES	NO
Have you had orthodontic therapy (braces)?	YES	NO
Does any part of your mouth hurt when you bite?	YES	NO
Are any of your teeth sensitive to: hot, cold, sweets, or pressure?	YES	NO
Do you suffer from frequent jaw pain?	YES	NO
Do you clench or grind your teeth?	YES	NO
Do you now or have you ever used a mouth guard?	YES	NO
Do you think you have dental decay, cavities?	YES	NO
Do you think you have gum disease?	YES	NO
Do your gums bleed when brushing or flossing?	YES	NO
Do you frequently have dry mouth?	YES	NO
Do you ever have a burning sensation in your mouth?	YES	NO
Do your ever have ulcers in your mouth?	YES	NO
Have you ever been treated for gum disease?	YES	NO

What is your most immediate dental concern? ____

____

____

Are there any dental procedure that you are interested in? ____

Patient or Responsible Party_____________________________________ **Date**____________________

Medical History

Are you currently under the care of a physician? Yes / No.
Name of Physician(s)________________________________ Phone__________________________________

YES NO Coumadin or other blood thinning agents including Asprin? (Please List) ___________________________
YES NO ALLERGIC TO ANY MEDICATIONS OR MATERIALS
- **YES NO Latex**
- **YES NO Metals**
- **YES NO Local anesthetics**
- **YES NO Penicillin or other antibiotics**
- **YES NO Sulfa drugs**
- **YES NO Codeine or other narcotic**
- Other: _______________________________

Please list ALL medicines you are currently taking:
____
____
____
____
____
____

YES NO Previous heart attack
YES NO Chest pain
YES NO Angina
YES NO Shortness of breath
YES NO High blood pressure
YES NO Heart murmur
YES NO Artificial heart valve
YES NO Congestive heart failure
YES NO Stroke
YES NO Pacemaker
YES NO Rheumatic fever
YES NO Endocarditis
YES NO Congenital heart defect
Other heart ailment:___________________________
YES NO Easy Bruising
YES NO Abnormal bleeding
YES NO Hemophilia
YES NO HIV/AIDS
YES NO Anemia
YES NO Asthma
YES NO COPD or other lung disease. ________________
YES NO Tuberculosis
YES NO Seasonal allergy
YES NO Arthritis
YES NO Osteoporosis
YES NO Pins or rod in bone
YES NO Previous joint replacement
YES NO Gastrointestinal disease. __________________
YES NO G.I. Reflux
YES NO Eating disorder
YES NO Systemic lupus erythematosus
  YES NO Other autoimmune disease(s).
  ____
YES NO Thyroid problems
YES NO Migraine or severe headache

YES NO Diabetes. Type I or II
YES NO Excessive thirst

YES NO Frequent urination
YES NO Numbness or tingling in hands or feet
YES NO Kidney problems
YES NO Rapid weight gain
YES NO Recurrent infection
YES NO Hepatitis. What kind? ____________________
YES NO Liver disease. What kind? _________________
YES NO Epilepsy
YES NO Seizure disorder
YES NO Neurological disorder
YES NO Cancer. ______________________________
YES NO Radiation or chemotherapy

Women Only
YES NO Are you pregnant?
  Number of weeks:_______________
Doctor's name _________________________
Doctor's phone number __________________
YES NO Nursing
YES NO Taking birth control pills
YES NO Hormone replacement
  YES NO Have you ever been diagnosed with gestational Diabetes?

To the best of my knowledge, all of the preceding answers are correct. If any health status or changes of medicines occur I will inform this office.

Patient Signature______________________Date________

Doctore Signature______________________Date________