PATIENT and ACCOUNT INFORMATION **Today's Date:**_____

Patient Last Name:_____ **First Name:**_____ **M.I.:**____

Title: (circle one): Mr. / Mrs. / Miss / Ms. / Master / Dr. / other:_____ **Nickname:**_____

Home Phone:(____**)**_____ **Work Phone: (**_____**)**_____ **Cell :(**_____**)**_____

Residence Address:_____ **Apt**_____ **City:**_____ **State:**___ **Zip:**_____

Patient's Birthdate:_____ **SSN:**_____ **Pt. Personal e-mail address:**_____

Occupation:_____ **May we call you at work? Yes No** **Driver's Lic.#**_____ **State**___

Employer Name _____ **Phone#** _____ **work email:**_____

Name of nearest relative (not residing at your address): _____ **Ph:**_____

Whom should we thank for referring you (your family) to our office? _____

*****IF PATIENT IS NOT PAYING THE BILL, provide the following information:**

Relationship of patient to person responsible for this account: Spouse___ Child___ Other:_____

Name of the person responsible for the patient's account: _____

Responsible Party Address:_____

City, State, ZipCode :_____ **Personal email:**_____

Home Phone:(____**)**_____ **Cell phone:(**_____**)**_____ **Pager: (**____**)**_____

Personal email: _____

Birthdate:_____

Driver's Lic. No.:_____ **State:**____

SSN:_____

Occupation:_____

Employer:_____

Employer Address:_____

City, State, Zip: _____

Employer Phone#: _____

Work Phone:(____**)**_____ **ext.**_____

May we call at work? Y N

Your Work email:_____

*****PRIMARY DENTAL INSURANCE INFO**

Pt's relation to insured: Self Spouse Child Other

Policyholder's Name: _____

" **I.D.#(or SSN):** _____ **Birthdate:**_____

" **Employer:** _____

Contact Person: _____ **phone ext.**____

Insurance Co.: _____

" **Address :** _____

" **City, State, Zip:** _____

" **Phone#: (**_____**)**_____

Policy/Group Number: _____

RESPONSIBLE PARTY MUST READ AND SIGN THAT YOU UNDERSTAND AND AGREE TO THE FOLLOWING FINANCIAL POLICY OF SPENCER R. BLOOM, D.D.S. :

I certify that the information provided above is correct and that I take full responsibility for payment of this account. I understand I am expected to pay my balance at the time of service minus guesstimated insurance benefits and that all unpaid balances are billed at 1.5%/month (18%annual) (min. billing charge of $5/mo.after 30days). I understand that Dr. Bloom will request payment from the Insurance Co. on my behalf, but when completed services have gone unpaid 30 days by my Insurance Co., I am expected to pay within 10 days, after which my statement will show interest or $5 billing charge specified above.

I understand balances unpaid beyond 60 days may be sent to an outside collection agency and that I am responsible for all costs of collection, in addition to the account balance, including but not limited to our attorney fees.

I understand that I can pay in full at the time of service, submit my own claims to the Insurance Co. and receive a 5% discount on the total. (Discount is 2.5% for charges/payments under $300)

I agree to the above financial policy of Spencer Bloom, DDS:

Date: _____ **Signature of Person Responsible for this account**_____

Medical and Dental Information

Patient Name: _____ Age:_____

PATIENT MEDICAL INFORMATION:

Do you have a personal physician? Y N Physician's Name, phone #: _____

Your current medical health is : __Good __Fair __Poor Are you currently under the care of any physician? _Y _N

If yes, explain: _____

Are you currently taking any prescription **or** non-prescription medications? Please list: _____

_____

Other than current conditions described above, please indicate if you have ever had any of the following:

__Heart Attack/Stroke
__Heart Murmur/Rheumatic Fever
__Heart Surgery/Pacemaker
__Chronic/Acute Hepatitis/Jaundice
__Anemia
__High/Low Blood Pressure
__Severe Headaches/Migraine
__Epilepsy/Seizures/Fainting spells
__Drug/Alcohol Abuse
__Hemophilia/Blood Disorder
__Cancer/Chemotherapy
__Stomach/Intestinal problem
__Diabetes
__Kidney Problems
__Sinus Problems
__Fever Blisters/Cold Sores
__Psychiatric Problems
__Arthritis/Rheumatism
__Donor Organs, transplants, implants, artificial valves or joint replacements
__Lung Problems/Tuberculosis (TB)
__Unusually high stress/tension levels
__Venereal Disease/STD
__HIV+ / Aids
__Canker Sores
__Other, not mentioned above_____

Are you allergic to any of the following? (Circle or list all allergies you have): Penicillin / Erythromycin / Tetracycline / Aspirin / Codeine / Dental Anesthetic / Latex / other:_____

__Y __N Do you smoke or use tobacco in any other form? _____

Women Only: __Y __N Are you pregnant? __Y __N Are you taking oral contraceptives?

(Women, be advised: many antibiotics make oral contraceptives temporarily useless. Ask pharmacist or OB/GYN for advice.)

PATIENT DENTAL INFORMATION

Approximate date and purpose of your last dental visit:_____

Why have you come to the dentist today? _____

__YES __NO Do you have pain or painless clicking in or near your ear (ie. In the jaw joint)?
__YES __NO Do you have any unhealed injuries or inflamed areas in or around your mouth, head or neck?
__YES __NO Have you experienced any growths or recurring sore spots in the mouth or around head or neck?
__YES __NO Any reactions or allergic symptoms related to a dental problem or dental treatment?
__YES __NO Have you had prolonged bleeding, numbness or pain following tooth extraction(s)?
__YES __NO Do you habitually clench or grind your teeth during the day or night? Snore heavily? Apnea?
__YES __NO Does any part of your mouth hurt when clenched?
__YES __NO Do you chew on only one side of your mouth? If yes, which side?_____
__YES __NO Do your routinely use mouthwash and/or breath fresheners? Brand:_____
__YES __NO Do your gums bleed? Do you use dental floss 4 or more times per week?__YES __NO
__YES __NO Are you interested in learning ways to improve the way your teeth look? Freshen your breath?

When and where was your last thorough, complete dental checkup? (not emergency visit)

_____

__YES __NO If needed, may we request your dental x-rays?DDS Name & phone #:_____

In your previous dental experiences, were there things you strongly liked or disliked and want us to know about?:_____

Please note: while in the dental chair, we offer a wide range of music, movies, and documentaries to keep you occupied and distracted during treatment. Let the staff know what you like and the chances are that can find something for you.

****CERTIFICATION: I certify that I understood all questions asked and that I answered all questions truthfully. I understand that it is my responsibility to inform this office of any changes in my medical or dental status.**

Date: _____ Signature: _____