T.J. EMMER
Prosthetic Dentistry

PATIENT INFORMATION

DATE:		PATIENT STATUS: NEW UPDATE		
NAME:				
	FIRST NAME	LAST NAME	MIDDLE INITIAL	PREFERRED
GENDER:	MALE FEMALE	MARITAL STATUS: SINGLE MARRIED		DIVORCED OTHER
PATIENT DATE OF BIRTH:			PATIENT SSN:	
ADDRESS LINE 1:				
ADDRESS LINE 2:				
CITY		STATE	ZIP CODE	
HOME:		CELL:		E-MAIL:
HOW DID YOU LEARN ABOUT OUR PRACTICE?				
WHOM MAY WE THANK FOR REFERRING YOU?				
IF CHILD, PROVIDE PARENT/GUARDIAN INFORMATION:				
PARENT/GUARDIAN NAME(S):			DATE OF BIRTH: SSN:	
ADDRESS:			PHONE:	

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, PLEASE PROVIDE INFORMATION FOR THE NEAREST RELATIVE OR CONTACT PERSON NOT AT THE PATIENT'S ADDRESS:

NAME		RELATIONSHIP	TELEPHONE

EMPLOYMENT INFORMATION (IF MINOR, PARENT/GUARDIAN INFORMATION)

EMPLOYER:		OCCUPATION:			
ADDRESS:		CITY:		STATE:	ZIP:

INSURANCE INFORMATION

PRIMARY SUBSCRIBER:	PRIMARY INSURANCE CARRIER:
SUBSCRIBER DATE OF BIRTH:	ID NUMBER:
SUBSCRIBER EMPLOYER:	GROUP/POLICY NUMBER:
SUBSCRIBER SSN:	TELEPHONE NUMBER:
PATIENT RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER:	

PRIMARY PHYSICIAN NFORMATION

PHYSICIAN:	TELEPHONE:

MEDICAL HISTORY

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS? YES NO

IF YES, FOR WHAT REASON?

DO YOU USE TOBACCO IN ANY FORM? YES NO IF YES, PLEASE DESCRIBE:

DOES YOUR PHYSICIAN (DOCTOR) REQUIRE YOU TO PRE-MEDICATE PRIOR TO DENTAL PROCEDURES? YES NO

ARE YOU CURRENTLY NURSING? YES NO	CURRENTLY PREGNANT? YES NO

DO YOU KNOW OF ANY REASON WHY ROUTINE DENTAL PROCEDURES MIGHT POSE A RISK TO YOU, OUR STAFF, OR OTHER PATIENTS? YES NO
IF YES, PLEASE DESCRIBE:

IS THERE ANYTHING IMPORTANT ABOUT YOUR MEDICAL HISTORY WE HAVE NOT ASKED? YES NO

IF YES, PLEASE DESCRIBE:

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):		
Heart (*Surgery, Disease, Attack*)	Diabetes	A.I.D.S.
Chest Pain	Thyroid Problems	H.I.V. Positive
Congenital Heart Disease	Glaucoma	Cold Sores/Fever Blisters
Heart Murmur	Contact lenses	Blood Transfusion
High Blood Pressure	Emphysema	Hemophilia
Mitral Valve Prolapse	Chronic Cough	Sickle Cell Disease
Artificial Heart Valve	Tuberculosis	Bruise Easily
Heart Pacemaker	Asthma	Liver Disease
Rheumatic Fever	Hay Fever	Yellow Jaundice
Arthritis/Rheumatism	Latex Sensitivity	Neurological Disorder
Cortisone Medicine	Allergies or Hives	Epilepsy or Seizures
Swollen Ankles	Sinus Trouble	Fainting or Dizzy Spells
Stroke	Radiation Therapy	Nervous/Anxiety
Diet (*Special/Restricted)*	Chemotherapy	Psychiatric or Psychological Care
Artificial Joints (*Knee, Hip, etc.)*	Tumors	None of the above
Kidney Trouble	Hepatitis	Other:
Ulcers	Venereal Disease	Other:

ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):		
ASPIRIN	LATEX	PENICILIN /ANTIBIOTICS
ANESTHETIC – LOCAL	METAL SENSITIVITY	SULFA DRUGS
CODEINE	NITROUS OXIDE	OTHER:
		NONE

CURRENT MEDICATIONS

ARE YOU TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):			
ANTIBIOTICS/SULFA DRUGS	ANTHISTAMINE/ALLERGY	DAILY ASPIRIN	BLOOD PRESSURE MEDICATIONS
BLOOD THINNERS	CANCER/CHEMO MEDICATIONS	CORTISONE/STEROIDS	HEART MEDICATIONS/DIGITALIS
INSULIN	NITROGLYCERIN	ORAL CONTRACEPTIVES	TRANQUILIZERS
OTHER DIABETIC MEDICATIONS	RECREATIONAL DRUGS	THYROID MEDICATIONS	OTHER (PLEASE LIST BELOW)

ARE YOU TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS/DRUGS? *IF YES, LIST BELOW:*

DRUG NAME	DOSAGE	REASON PRESCRIBED

PREVIOUS DENTIST INFORMATION

DENTIST:		TELEPHONE:

DENTAL HISTORY

DATE OF LAST DENTAL VISIT:

HOW OFTEN DO YOU BRUSH YOUR TEETH? FLOSS?

DO YOUR GUMS BLEED? WHEN? BRUSHING FLOSSING OTHER:

DO YOU HAVE ANY DENTAL PROBLEMS NOW? YES NO
IF YES, PLEASE DESCRIBE

DO YOU HAVE ANY TOOTH SENSITIVITY?	YES	NO	HAVE YOU HAD PERIODONTAL TREATMENT?	YES	NO
HAVE YOU NOTICED ANY ODORS OR BAD TASTES?	YES	NO	DO YOU WEAR A MOUTH GUARD?	YES	NO
DO YOU GET ORAL LESIONS OR COLD SORES?	YES	NO	DO YOU WEAR A BITE PLATE/ MOUTH GUARD?	YES	NO
DOES FOOD GET CAUGHT BETWEEN YOUR TEETH?	YES	NO	HAVE YOU HAD A SERIOUS MOUTH INJURY?	YES	NO
DO YOU CLENCH OR GRIND YOUR TEETH WHILE SLEEPING?	YES	NO	DO YOU GET REGULAR HEADACHES?	YES	NO
DO YOU HOLD FOREIGN OJBECTS WITH YOUR TEETH?	YES	NO	DO YOU HAVE ANY DIFICULTY CHEWING?	YES	NO
DO YOU SNORE? OR MOUTH BREATHE?	YES	NO	ARE YOU NERVOUS AT THE DENTIST?	YES	NO
DO YOU HAVE TIRED JAWS?	YES	NO	DO YOU LIKE HOW YOUR TEETH LOOK?	YES	NO
HAVE YOU EVER HAD ORTHODONTIC TREATMENT?	YES	NO	HAVE YOU HAD ORAL SURGERY?	YES	NO
DO YOU HAVE ANY LOOSE TEETH?	YES	NO	HAVE YOU NOTICED A CHANGE IN YOUR BITE?	YES	NO

PATIENT AGREEMENTS

WE ARE COMMITTED TO PROVIDING YOU THE BEST CARE POSSIBLE TO ACHIEVE TOTAL ORAL HEALTH. IN ORDER TO ACHIEVE THESE GOALS, WE NEED YOU TO UNDERSTAND AND AGREE WITH OUR PRACTICE POLICIES.

FINANCIAL & INSURANCE

- PLEASE BE ADVISED, THOMAS J EMMER, DDS, PA IS **A NON-PARTICIPATING PROVIDER**. IT IS THE PATIENT'S RESPONSIBILITY TO ENSURE HIS/HER BENEFITS. YOU MAY REGARD YOUR INSURANCE BENEFITS AS ASSISTANCE TOWARDS YOUR TREATMENT FEES. YOU CAN READ ABOUT WHY WE CHOSE NOT TO PARTICIPATE WITH INSURANCE CARRIERS HERE.
- **WE ARE MORE THAN HAPPY TO ASSIST IN FILING A CLAIM WITH YOUR INSURANCE COMPANY AS A COURTESY. HOWEVER, WE DO NOT RECEIVE ROUTINE CORRESPONDENCE FROM YOUR CARRIER AND WE DO NOT WAIT ON THIRD-PARTY PAYMENTS. PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE.**
- AS A CONDITION OF YOUR TREATMENT BY THIS OFFICE, FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE. THIS PRACTICE DEPENDS UPON REIMBURSEMENT FROM OUR PATIENTS FOR THE COSTS INCURRED IN THEIR CARE TO REMAIN VIABLE. THEREFORE, FINANCIAL RESPONSIBILITY ON THE PART OF EACH PATIENT MUST BE DETERMINED BEFORE TREATMENT.
- ALL EMERGENCY DENTAL SERVICES, OR DENTAL SERVICES PERFORMED WITHOUT PREVIOUS FINANCIAL ARRANGEMENTS, MUST BE PAID FOR, IN FULL, AT THE TIME THE SERVICES ARE RENDERED.

BROKEN APPOINTMENT POLICY

- I UNDERSTAND THERE IS A NO SHOW FEE CHARGED FOR ALL APPOINTMENTS CANCELLED WITH LESS THAN 48 HOURS OR 2 BUSINESS DAYS NOTICE. WE UNDERSTAND LIFE HAPPENS AND WE WILL WAIVE THIS FEE FOR THE FIRST INCIDENT. AFTER THAT, THE FEE IS $50, AND IT WILL BE CHARGED FOR YOUR 2ND INCIDENT AFTER WHICH A $50 DEPOSIT WILL BE REQUIRED FOR ALL FUTURE APPOINTMENTS.

PATIENT CONSENT & AUTHORIZATION

- TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH STATUS OR IF MY MEDICATIONS CHANGE, I SHALL INFORM THE DENTIST AND STAFF AT THE NEXT APPOINTMENT WITHOUT FAIL.
- I HERBY AUTHORIZE THOMAS J EMMER, DDS, PA TO RELEASE ANY INFORMATION CONCERNING MY HEALTH OR DENTAL CARE, ADVICE, TREATMENT OR SUPPLIES PROVIDED. THIS INFORMATION IS TO BE USED IN ADMINISTERING DENTAL CLAIMS AND/OR DISCUSSING TREATMENT OPTIONS WITH OTHER DENTAL PROFESSIONALS.
- I HEREBY AUTHORIZE THOMAS J EMMER OR DESIGNATED STAFF TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, AND OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DR. EMMER TO MAKE A THOROUGH DIAGNOSIS.
- UPON SUCH DIAGNOSIS I AUTHORIZE DR. EMMER TO PERFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON BY ME AND TO EMPLOY SUCH ASSISTANCE AS REQUIRED TO PROVIDE PROPER CARE.
- I AGREE TO THE USE OF ANESTHETICS, SEDATIVES AND OTHER MEDICATION AS NECESSARY. I FULLY UNDERSTAND THAT USING ANESTHETIC AGENTS EMBODIES CERTAIN RISKS. I UNDERSTAND I CAN ASK FOR A COMPLETE RECITAL OF ANY POSSIBLE COMPLICATIONS.
- I GIVE THOMAS J. EMMER, DDS, PA PERMISSION TO USE THE FOLLOWING COMMUNICATIONS (PLEASE CHECK ALL THAT APPLY):
  - CELL PHONE
  - TEXT MESSAGE REMINDERS
  - HOME PHONE
  - WORK PHONE
  - E-MAIL
- I AM GRANTING PERMISSION FOR THOMAS J EMMER, DDS, PA TO DISCLOSE THEIR IDENTIY TO ANYONE WHO MAY ANSWER MY HOME, WORK, OR CELL PHONE.
- I AM GRANTING PERMISSION FOR THOMAS J EMMER, DDS, PA TO LEAVE A MESSAGE WITH ANY PERSON WHO MAY ANSWER MY PHONE OR MY VOICEMAIL AT THE FOLLOWING NUMBERS (PLEASE CHECK ALL THAT APPLY):
  - HOME PHONE
  - CELL PHONE
  - WORK PHONE
  - NONE- PLEASE JUST ASK FOR A CALL BACK

I GIVE PERMISSION FOR THE FOLLOWING PERSON(S) TO HAVE ACCESS TO PERSONAL INFORMATION INCLUDING BUT NOT LIMITED TO APPOINTMENTS, TREATMENT, AND BILLING FOR MYSELF AND ANY DEPENDENT CHILDREN.

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BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS MENTIONED ABOVE.

PATIENT NAME SIGNATURE: DATE: