GEISE DENTAL
FAMILY & COSMETIC

**All patients, please read and initial the following:**

Initial

- For each appointment, we reserve a patient room, your records and insurance is pre-checked and special instruments are prepared. Due to the preparation time involved, please give at least 48-hours notice to change or cancel your appointment. ---------
- We ask that you pay any deductible or co-pay at the time of service. ---------
- We are pleased to offer Care Credit financing. Please ask about our no interest plans. ---------
- If you have insurance, we will do our best to accurately **estimate** your out-of-pocket expenses. However, the insurance company reserves the right to pay a different portion or deny payment of any claim. Please know that you are responsible for any charges your insurance does not cover for each procedure. ---------
- Please notify us if you have secondary dental insurance. As a courtesy to you we process secondary dental claims and make every effort to ensure an accurate estimate of your out-of-pocket cost. Please note that some secondary dental insurance may deny payment if primary insurance pays any portion of a claim. ---------
- Please note that if your insurance company does not cover a service or fails to pay your claim within 90-days, your balance is due in full. ---------
- Insurance companies require your authorization for Geise Dental to receive payments from your insurance company. Your signature below authorizes direct payment to Peterson Dental from your insurance company. ---------
- **I have thoroughly read and understand the above conditions of payment and treatment and agree to these conditions.**

Patient/Guardian Signature:_____Date_____

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**Patient Information:**

Patient Name: _____

Preferred Name: _____

Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Birthdate: _____

Patient's SSN: _____

DL #: _____

Mailing Address: _____

_____

Email Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Text me appointment reminders: ❑ Yes ❑ No

**Insurance Information:**

**Primary Insurance:**

Policy Holder's Name:

Employer: _____

Insurance Company Name: _____

Policy Holder's SSN: _____

Policy Holder's Date of Birth: _____

Group #: _____

Contract #: _____

**Secondary Insurance:**

Policy Holder's Name: _____

Employer: _____

Insurance Company Name: _____

Policy Holder's SSN: _____

Policy Holder's Date of Birth: _

Group #: _____

Contract #: _____

What brings you to our office today? _____

How did you learn about us? _____

Is there anything about your teeth that you would like to change? _____

Would you like to whiten your smile? ❑ yes ❑ no ❑ unsure

Do your gums ever hurt or bleed when you brush/floss? ❑ yes ❑ no ❑ unsure

Do you grind your teeth? ❑ yes ❑ no ❑ unsure

**Emergency Contact Information:**

Name:_____ Relationship:_____ Phone Number: _____

**Acknowledgement of Privacy Practices:** I have been offered/read/received if requested a copy of the Notice of Privacy Practices.

Patient/Guardian Signature:_____ Date: _____

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## Medical Health History

**Please check all that apply:**

- ❑ Do you pre-med for dental procedures?
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ AIDS or HIV positive
- ❑ Alcoholism
- ❑ Allergies or sinus problems
- ❑ Anemia or blood disorders
- ❑ Arthritis
- ❑ Artificial joint or valve replacement
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Blood thinners List: _____
- ❑ Cancer
- ❑ Chewing tobacco
- ❑ Cold sores
- ❑ Diabetes
- ❑ Drug abuse
- ❑ Emotional condition
- ❑ Epilepsy
- ❑ Epinephrine problems
- ❑ Fainting spells
- ❑ Heart condition Type: _____
- ❑ Hepatitis or other liver disease Type: _____
- ❑ Herpes
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Low blood pressure
- ❑ Migraine headaches or frequent headaches
- ❑ Neurologic condition
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Rheumatic fever
- ❑ Seizures
- ❑ Smoker
- ❑ Steroid treatment
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other lung problems Specify: _____

Women:

- ❑ Take hormones or contraceptives
- ❑ Pregnant - expected due date: _____

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin
- ❑ Codeine or other narcotics: _____
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other: _____

Have you ever taken any **bisphosphonates** such as Boniva, Fosamax, Actonel, Zometa, Aclasta?
If so please list: _____

_____

_____

Please list all of your **current medications:**

_____

_____

_____

Please list any **surgeries** with dates:

_____

_____

_____

Do you have any condition not listed above? _____

**Physician Contact Information:**

Name: _____ Phone Number: _____

Patient/Guardian Signature: _____ Date: _____