WELCOME

TO OUR PRACTICE

PERSONAL AND HEALTH INFORMATION
(CONFIDENTIAL)

Steven Hochfelder DMD, PA

FAMILY AND COSMETIC DENTISTRY

Patient Information (Please Print)

Name_____ Date_____ S.S #_____
First Last

Address_____ City_____ State_____ Zip_____

Birthdate_____ Home#_____ Cell#_____ Work#_____

Email_____ Marital Status_____ Sex M F

Your Employer_____ Occupation_____

Spouse's or Parent's name_____ Workplace_____ Work Phone #_____

Who may we thank for referring you to us?_____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone # _____

Please Check form of Payment:

- ❑ Insurance and patient's co-payment at each visit
- ❑ Payment in full at each visit
- ❑ Billing through VISA, MasterCard , American Express or Discover

Insurance Information

Insurance Claims are submitted as a courtesy to our patients. Accepting Assignment results in a delay of payment of three to six weeks or longer. Our policy is to accept assignment of insurance benefits if you furnish the following information. Benefits are estimated at 50% of the total (less deductibles) until a copy of your policy is provided. Insurance payment under most plans is based on a percentage of the prevailing and customary charges for the area, not on a percentage of our charges. If the insurance does not pay the estimated charge, the patient is responsible for the balance, which is due in full within 30 days after the insurance payment is received.

Name of insured_____ Relationship to patient _____

Birthdate of insured_____ Social Security # of insured _____

Name of employer _____ Work phone # _____

Address_____ City_____ State_____ Zip_____

Insurance Co. _____ Policy # _____ Insurance Co. Phone #_____

Insurance Co. Address _____ City_____ State_____ Zip_____

Member I.D. _____ Group # _____

Dental History

Please check any of the following conditions that apply to you:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding, clenching teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

Reason for today's visit: _____

Medical History

TO OUR NEW PATIENTS

The questions contained in this questionnaire all have a direct bearing on your health and may be significant in providing treatment for you comfortably and safely; therefore, it is important that you answer the following questions. Please remember *the answers to these questions will be held in the strictest confidence.*

Yes No Are you under any medical treatment now?
Yes No Have you had any serious illness or operation?
Yes No Are you taking any drugs or medication?
Yes No Women - Are you pregnant?

Do you have or have you had any of the following? If yes, please check:

- ❑ Rheumatic Fever
- ❑ Heart Murmur
- ❑ Any Heart Ailment
- ❑ High or Low Blood Pressure
- ❑ Anemia
- ❑ Blood Disorder
- ❑ Bleeding Problems
- ❑ Diabetes
- ❑ Kidney Trouble
- ❑ Hepatitis, Jaundice or Liver Disease
- ❑ Tuberculosis or Venereal Disease
- ❑ Convulsions or Epilepsy
- ❑ Tumors or Growths
- ❑ Allergies
- ❑ Dizziness or Fainting
- ❑ Asthma, Hayfever or Sinusitis

Medications currently being taken by patient:

_____
_____
_____
_____

Patient Comments: _____

_____
_____
_____
_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (Or parent if a minor) **DATE**

We shall endeavor to make your visits as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, appointment or fees, please feel free to ask. In order to minimize bookkeeping time and therefore eliminate unnecessary fee increases, all fees for professional services will be paid at time of treatment or billed through VISA, MasterCard, American Express or Discover, if eligible. If unable to keep a scheduled appointment, please give us at least 24 hours notice. ***We reserve the right to charge for broken or cancelled appointments without 24 hours notice.***