Patient Information

Legal Name: (Last)________________ (First)________________ (Middle)________________

Address:________________________________ Marital Status:__________ Sex:__________

City:________________________________ State:__________ Zip:__________

Drivers License #:________________________ Social Security #:________________

Your Employer:________________ Address:________________________

Your Occupation:________________ **Referred By:**________________________

Are you a full-time college student?________ If so, where?________________________

Please note all ways in which we may contact you:

Telephone: (Home)________________________ (Work)________________________

Cell Phone: ________________________ e-mail: ________________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Legal Name:________________________ Relationship:__________ SS#:________________

Address:________________________________ Date of Birth:__________

City:________________________________ State:__________ Zip:__________

Please note all ways in wich we may contact the responsible party:

Telephone: (Home)________________________ (Work)________________________

Cell Phone: ________________________ e-mail: ________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co.:____

Insurance Co. Address:____

Employee:________________ Relationship:__________ SS#:__________ DOB:__________

Employer:________________________ Contract # /Group #:________________

Secondary Insurance Co.:____

Insurance Co. Address:____

Employee:________________ Relationship:__________ SS#:__________ DOB:__________

Employer:________________________ Contract # / Group #:________________

I, the undersigned patient or legal guardian of the patient, hereby authorize and direct the above insurance carrier(s) to make checks or payments for dental expenses incurred by me directly payable to Dr. O'Neill. I also authorize the release of any information regarding my dental condition or dental treatment to said insurance carrier(s) as may be necessary for billing and collection purposes. I further understand that I am responsible for all dental expenses and agree to pay any expenses not covered by my insurance. ***There is a $25.00 service charge on all returned checks. Appointments missed or cancelled without 24 hour notice will be subject to a charge. There will be a 30% collection fee for all accounts turned over to an outside agency in attempt to collect monies due this office.** I have read, fully understand and agree to all of the policies stated in this contract.

Signature: **Date:**

Patient Medical History

Patient Legal Name (Last)________________ (First)________________ (Middle)________________

Date of Birth________________ Family Physician________________ Physician Phone #________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
List Reasons:________________		
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 2 years?	☐	☐
If yes, please explain________________		
3. List any medication(s) including non-prescription medicine you are currently taking?________________		☐
________________		
________________		
4. Do you smoke?	☐	☐
If yes, how long have you smoked?________________		
How many packs per day do you smoke?________________		
5. Do you use any other tobacco products?	☐	☐
If yes, what type?________________		

	Yes	No
6. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (eg. Novacaine)	☐	☐
Penicillin or any other Antibiotic________________	☐	☐
________________		
Ibuprofen	☐	☐
Aspirin	☐	☐
Any Metals (eg. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other________________	☐	☐
7. **FOR WOMEN ONLY**:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐

Do you have or have you had any of the following listed below?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Stroke	☐	☐
Heart Attack	☐	☐	Mitral Valve Prolapse	☐	☐	Radiation Therapy	☐	☐
Rheumatic Fever	☐	☐	Cardiac Pacemaker	☐	☐	Glaucoma	☐	☐
Fainting/Seizures	☐	☐	Heart Murmur	☐	☐	Liver Disease	☐	☐
Asthma	☐	☐	Angina	☐	☐	Respiratory Problems	☐	☐
Low Blood Pressure	☐	☐	Heart Valve Replacement	☐	☐	Thyroid Problem	☐	☐
Epilepsy/Convulsions	☐	☐	Anemia	☐	☐	Joint Replacement or Implant	☐	☐
Diabetes	☐	☐	Emphysema	☐	☐	Hepatitis/Jaundice	☐	☐
Kidney Diseases	☐	☐	Cancer	☐	☐	Stomach Troubles/Ulcers	☐	☐
AIDS or HIV Infection	☐	☐	Arthritis	☐	☐			

Signature________________________________ Date________________

I have reviewed the above MEDICAL HISTORY. My health and medications have changed as follows:

Date__________ Signature________________
(Patient or Legal Guardian)

Changes:________________________________

Date__________ Signature________________
(Patient or Legal Guardian)

Changes:________________________________

Date__________ Signature________________
(Patient or Legal Guardian)

Changes:________________________________

Date__________ Signature________________
(Patient or Legal Guardian)

Changes:________________________________

Date__________ Signature________________
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(Patient or Legal Guardian)

Changes:________________________________

Date__________ Signature________________
(Patient or Legal Guardian)

Changes:________________________________