

WELCOME

TO OUR PRACTICE



Steven Hochfelder DMD, PA

FAMILY AND COSMETIC DENTISTRY

PERSONAL AND HEALTH INFORMATION **(CONFIDENTIAL)**

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

☐ Billing through VISA, MasterCard, American Express or Discover

☐ Payment in full at each visit

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 | ☐ Grinding, clenching teeth | ☐ Sensitivity to hot |
| ☐ Bleeding Gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Periodontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ 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? |

Medications currently being taken by patient:

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

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

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.**