Chart #: ______
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date: ______
Last, First MI (Preferred Name)
Gender: ______ Family Status: ______

Social Security #: ______ Birth Date: ______

Phone (Home): ______ (Work): ______ Ext: ______ Cell Phone

EMAIL: ______ EMAIL: ______ @ ______

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ______
Street Apartment #

______
City State Zip Code

Health Information

Date of Last Dental Visit: ______ Reason for visit: ______

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergy or Adverse Reaction to any Medication (s) ______
☐ Any Environmental Allergies? ______
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dental Implants
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Hip Replacement
☐ Thyroid disorders/meds
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders

☐ Pacemaker/Defibrillator
☐ **Pregnancy** Due date: ______
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

☐ Latex Allergy
☐ Have you ever take medication containing Bisphosphonate? Such as Fosamax, Boniva, or Actonel.
☐ Have you ever taken Prolia, Denosumab?

Have you ever had orthodontic treatment or braces?

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______
- Name of Physician: ______ Phone: ______
- Are you currently taking any medications? ☐ Yes ☐ No For what condition(s)? ______
- **List current medications:** ______

______

- **Is there anything else we should know about your medical history?** ☐ Yes ☐ No
  If yes, please explain: ______

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______ Date: ______
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ______________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: __________ Birth Date: __________

Phone (Home): __________ (Work): __________ Ext: ______ Cell Phone

Address: ______________________

Street Apartment #

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: __________ Occupation: __________

Address: ______________________

Insurance Information Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________

Street City State Zip Code

Insured's Employer Name: ______________________

Address: ______________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Dependant Child: student status/school Attending? __________

Insurance Plan Name and Address: ______________________

Secondary

Name of Insured: ______________________ is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________

Street City State Zip Code

Insured's Employer Name: ______________________

Address: ______________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Dependant Child: student status/school Attending? __________

Insurance Plan Name and Address: ______________________

CONSENT TO SERVICES

I as a patient or guardian fully understand and agree with the following:

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash, check, or credit card at the time services are performed.

We will be happy to submit claims to your insurance company on your behalf. Please understand that insurance is not a guarantee of payment; should the insurance company deny coverage the patient will be ultimately responsible for payment. It is important that you notify our office as soon as possible if there are any changes to your dental insurance.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I also understand and agree that if my account becomes delinquent that there will be an increase of 40% over the total outstanding balance to cover all reasonable collection proceedings.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. This office will make every effort to adhere to the original treatment plan estimate. However, there are circumstances beyond our control that my dictate the change in the treatment or estimate.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________ Date: __________ Relationship to Patient: __________

Signature of patient, parent or guardian

______________________ Date: __________ Relationship to Patient: __________

Signature of guarantor of payment/responsible party

MICHAEL V. BLEYZER D.D.S.
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Fax (845) 429-3570

In order for us to take better care of you, please answer these two questions:

- Is there any discomfort/pain in your mouth and or jaws/face?

- Is there anything you would like to improve about your smile?
(e.g. shape, alignment and color of your teeth?)