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Chart#: SI0020 ______________
FOR OFFICE USE ONLY

Patient Name: ______________ ______________ ___ ______________
Last First MI Preferred Name

Title: __________ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **Prev. Visit:** __________ **Email Address:** ______________________

Phone: __________ __________ __________ ______ **Best time to call:** ______________
Home Mobile Work Ext

Address: ______________________ ______________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

To whom may we thank for referring you to our practice:

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ Work
☐ Other(name below)

Name of person, office, or other source referring you to our practice:

____

Emergency Contact

Who should we contact in case of an emergency(primary and alternate phone number. Please provide their relationship to you.

____
____
____
____

Spouse or Responsible Party Information

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: ______________ ______________ ___ ______________
Last First MI Preferred Name

Telephone Number(Primary)__________________(Secondary)____________________

Employment Information

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: ______________________________ **Phone:** ____________

Employer Address: ______________________ ______________________

Address 1 Address 2

______________________________ ______ _____-____

City State Zip Code

Primary Insurance Information

PAYMENT FOR ALL TREATMENT IS DUE AT THE TIME OF SERVICE.AS A COURTESY, OUR PRACTICE WILL FILE ALL INSURANCE CLAIMS AND ASSIST YOU IN OBTAINING THE MAXIMUM AVAILABLE BENEFIT. ALL BENEFITS PAYABLE BY YOUR INSURANCE COMPANY WILL BE PAID DIRECTLY TO YOU AS A REIMBURSEMENT. IF YOU HAVE A SECONDARY INSURANCE COMPANY, PLEASE PROVIDE THAT INFORMATION ON THE BACK OF THE FORM.

Primary Insurance Information(Please present card(s):

Name of Insured: ______________________ ______________________ ___

Last First MI

Insured's Birth Date: ____________ **ID #:** ____________________ **Group #:** ______________

Insured's Address: ______________________ ______________________

Address 1 Address 2

______________________________ ______ _____-____

City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________

Address 1 Address 2

______________________________ ______ _____-____

City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________

Address 1 Address 2

______________________________ ______ _____-____

City State Zip Code

Please take a moment to let us know about your medical and dental history .

What is the reason for your dental visit today?

____

____

When was your last visit to the dentist (if to a different office)? What was done?

____

____

Prior Dentist's name, address, & phone number:

____

____

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

If any of the previous questions are marked, please explain:

____

____

If you could change anything about your mouth, teeth, or smile, what would it be?

____

____

Would you consider yourself to be in fairly good health? YES NO

Within the past year, have there been any changes in your general health? YES NO

If yes, please explain:____

Please list all prescription and non-prescription medications:

____

____

____

____

____

WOMEN ONLY: Are you pregnant? YES NO (If yes, due date__________________)

What is the date (or approximate date) of your last medical exam?____________________________________

Your Primary Care Physician's name, address, & phone number:

____

____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

If any of the previous questions are marked, please explain:

____

____

MEDICAL HISTORY Please indicate if you have experienced any of the following:

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ ADD
☐ Allergy - Aspirin	☐ Allergy - Cephalospo	☐ Allergy - Codeine	☐ Allergy - Epinephrin
☐ Allergy - Erythro	☐ Allergy - Latex	☐ Allergy - Loc. Anest	☐ Allergy - Other
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Alpha Gal	☐ Anemia
☐ Antibiotics	☐ Anxiety	☐ Arthritis	☐ Artificial Joints
☐ Artificial Valve	☐ Asthma	☐ Autoimmune Disease	☐ Blood Disease
☐ Blood Thinners(Rx)	☐ Cancer	☐ CongestiveHeartFail	☐ COVID VACCINATED
☐ Crohn's Disease	☐ Diabetes	☐ Diverticulitis	☐ Dizziness
☐ Excessive Bleeding	☐ Fainting	☐ GERD	☐ Glaucoma
☐ Hashimoto's Disease	☐ Head Injuries	☐ Heart Attack (H/O)	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV	☐ Hormone Therapy	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Lymphoma	☐ Mental Disorders	☐ Migraines
☐ MVP	☐ Myesthenia Gravis	☐ Other	☐ Pacemaker
☐ Parkinsons	☐ Polycystic OD	☐ Pre-Diabetes	☐ PREDNISONE
☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Seizure disorder	☐ Sinus Problems	☐ Sleep Apnea	☐ Smokes +1pk/day
☐ Smokes 1pk-less/day	☐ Stroke	☐ Thyroid disease	☐ TIA's (H/O)
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

____

____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Every effort to ensure a clear understanding of the proposed treatment and the fees for the treatment will be made in advance of initiating treatment. Payment can be made by cash, check, Visa or Mastercard. If the cost of treatment is $500.00 or less, the entire amount is due in full at the time treatment is performed. If the cost of treatment is greater than $500.00, at least one-third of the total cost of the treatment is due at the time of initial treatment, with the balance to be paid in monthly installments throughout the course of treatment with the final installment due at completion of the treatment.

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

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Insurance is a contract between a patient and their insurance company. This office will help prepare the patients insurance forms and assist in making collections from insurance companies. We will request that any such collections be paid directly to the patient.

MEDICARE: DR. DE KOK IS NOT A MEDICARE PROVIDER. If you are eligible for Medicare and participate in a Medicare program, Dr. De Kok cannot bill to these programs nor may you submit your own claim to these programs whether services rendered are a covered expense or not.

I hereby certify that I have read and understand all of the policies written above, including the financial policies regarding insurance and third party payments.

MY SIGNATURE BELOW CERTIFIES MY UNDERSTANDING OF THE FINANCIAL POLICIES ABOVE

Signature of patient, parent, or guardian:____ Date:______________

If not the patient, please indicate relationship:_____________________________________

Response Date: _____________