Perfect Dental Bay City

Patient Information

Patient

Name _____
Address_____
City_____ **Zip** _____
Phone _____
E-mail _____
Social Security _____
Age _____**Birthdate**_____

Responsible Party

(If same as above, please skip)
Relationship to Patient _____
Name _____
Address_____
City_____ **Zip** _____
Phone _____
E-mail _____
Social Security _____
Age _____**Birthdate**_____

Emergency Contact

Name _____
Phone_____
Physician_____
Phone _____

Getting to Know You

Do you have family members who need dental care? If so, please list their name & relationship.
1._____**2.**_____
3._____**4.**_____

How did you hear about our office? (check one)
- ☐ **Facebook/Instagram**
- ☐ **Google**
- ☐ **Family/Friends**
- ☐ **Flyer**
- ☐ **Office Sign**
- ☐ **Insurance**
- ☐ **Radio**
- ☐ **Other**_____

Scan Here To Follow Us!

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
1. By signing below, tauthorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
1. authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that i am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
1. I understand that this dental practice is owned and operated by and independent dentist, I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

_____

Signature of Responsible Party **Date**

Medical & Dental History Form

Patient Name:_____ Date of Birth:_____

Dental History

Reason for today's visit? _____ Date of last dental care?_____

Former Dentist? _____ Date of last X Rays?_____

Please (√)if if you have had problems with any

☐ Bad Breath ☐ Bleeding gums ☐ Clicking or popping jar ☐ Grinding teeth

☐ Food collection between teeth ☐ Loose teeth or broken fillings ☐ Sensitivity to hot

☐ Sensitivity to cold ☐ Sensitivity to sweet ☐ Sensitivity when biting ☐ Sores or growths in mouth

Medical History

Physician's Name_____ Date last visit_____

Have you had and serious illnesses or operation? ☐ **YES or** ☐ **NO** yes,describe_____

Have you ever had a blood transfusion? ☐ **YES or** ☐ **No** If yes, give approximate dates_____

(Women)Are you pregnant? ☐ YES or ☐ NO Nursing? ☐ YES or ☐ NO

Please (√) if you have or had any of the following: NONE APPLY TO ME

☐ A.D.D/ A.D.H.D	☐ Blood disease	☐ Fainting	☐ Jaw pain	☐ Skin rash
☐ Anemia	☐ Cancer	☐ Glaucoma	☐ Kidney disease	☐ Stroke
☐ Arthritis, Rheumatism	☐ Chemical Dependency	☐ Heart problems	☐ Liver disease	☐ Swelling of feet
☐ Artificial heart valves	☐ Chemotherapy	☐ Hemophilia	☐ Pacemaker	☐ Thyroid Problems
☐ Artificial joints	☐ Circulatory problems	☐ Hepatitis	☐ Radiation treatment	☐ Tonsillitis
☐ Asthma	☐ Cortisone treatments	☐ High blood pressure	☐ Respiratory disease	☐ Tuberculosis
☐ Any fever	☐ Cough up blood	☐ Low blood pressure	☐ Seizure	☐ Ulcer
☐ Autism	☐ Diabetes	☐ HIV/AIDS	☐ Shortness of breath	☐ Venereal disease
☐ Back problems	☐ Epilepsy	☐ Heart murmur	☐ Smoking/Tobacco use	OTHER:_____

MEDICATIONS

List medications you are taking: IF NONE (√) ☐ **NONE**

_____

_____

_____

Pharmacy Name:_____

Phone:_____

Allergies

☐ **NONE** ☐ Penicillin ☐ Latex ☐ Ibuprofen

☐ Codeine ☐ Sulfa ☐ Tylenol

☐ Clindamyci ☐ Aspirin ☐ Other :

_____

_____

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Onsite Dental of any changes in my medical status.

Date:_____ Signature:_____

Perfect Dental of Bay City

Patient

Name:_____

Address:_____

City:_____ ZIP_____

Phone:_____

E.mail:_____

Social Security:_____

Age:_____Birthday:_____

Getting to know you

Do you have family members who may need dental care?
If so, please list name & relationship.
1._____2._____

How did you hear about us? (CHECK ONE)

- ❑ Family-Friend
- ❑ Internet/Google
- ❑ Flyer
- ❑ Insurance
- ❑ Office Sign
- ❑ Other

Responsible Party

(IF SAME AS ABOVE, PLEASE SKIP)

Name: _____

Address:_____

City:_____ ZIP_____

Phone:_____

Relationship to Patient: _____

Birthday: _____

Emergency Contact

Name:_____

Phone:_____

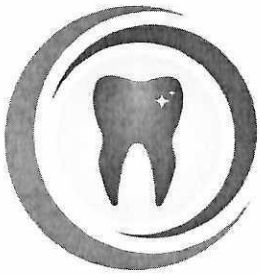
Physician:_____

Phone: _____

(If you have a physician)

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release any information relating to any dental claim or claims. 4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Signature of Responsible Party ***Date*** ***Next Page***



GENERAL MEDIA RELEASE FORM

In connection with dental services and/or treatment being rendered, I give permission for photographs/videos to be taken of me, with the following stipulations:

1. The photographs/videos may be taken by my dentist, a professional photographer, or a technician under their direction.

2. The photographs/videos may be used for social media, medical records, or as educational materials as deemed appropriate by my dentist.

3. I will not be identified by name other than for medical records purposes

Please Initial all that apply:

I _____ hereby understand and give consent for my photos/videos to be used for marketing purposes, including on the Practice website and Social Media platforms. I understand that my identity will not be disclosed without further consent. I understand that I might be identified by first name only and that my privacy will be protected as per HIPAA regulations.

I _____ DO NOT consent to have pictures/videos taken for social media platforms and or for website use.

Please Sign