HORTON & VRANAS D.D.S.

Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ **Date**:__________________
Last First MI (Preferred Name)

Gender: ☐ M ☐ F BirthDate:________Social Security #: _________________ ☐ Married ☐ Single ☐ Divorced ☐ *Widowed*

Phone Home: ________________ Work: ____________Ext: ___ Cell: ______________Spouse's Name:______________

Address:____
Street City State Zip Code

Employed By:____ **Insurance Change**: ☐ Yes ☐ No

Preferred Confirmation Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail ☐Text Msg

Email Address:________________________________ **Referred By**________________________________

Health Information

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

☐ Artificial Heart Valves
☐ Artificial Joints
PlaceDate:_____________
Type________________

☐ AIDS/HIV
☐ Asthma
☐ Cancer
Type________Year____
Chemo______
Radiation_____
☐ Diabetes DietControlled_
Insulin Dependant____
☐ Anemia
☐ Epilepsy/Seizures
☐ Emphysema

☐ Fainting/Dizziness
☐ Heart Attack
☐ Cardiac Stent/Year__
☐ Heart Problems
☐ Pacemaker
☐ Hemophilia
☐ Hepatitis
☐ HighBloodPressure
☐ LowBloodPressure
☐ Tuberculosis
☐ Arthritis/ Rheumatism
☐ Back Problems
☐ Blood Disease
☐ Drug/Alcohol Abuse
☐ Cocaine Use
☐ CirculatoryProblems

☐ CortisoneTreatments
☐ Glaucoma
☐ Seizures
☐ Kidney Disease
☐ Liver Disease
☐ PsychiatricCare
☐ Stroke
☐ ThyroidProblems
☐ Ulcer(s)
☐ Headaches
☐ Venereal Disease

Allergies

☐ Amoxicillin Allergy
☐ Aspirin Allergy
☐ Codeine Allergy

☐ Dental Anesthetics
☐ Latex Allergy
☐ Penicillin Allergy
☐ Tetracycline Allergy
☐ Sulfa Drug Allergy
☐ Other Drug Allergies
____
____
____
____
____

Do you smoke? Yes/No How many per day? ______Do you use chewing tobacco? Yes/No

Are you or have you ever taken Bisphosphonate therapy drugs: ie: Actonel, Boniva, Fosamax or Didronel for osteoporosis or certain types of cancer? Yes / No

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: ____

Name of Physician: ______________________________________ Phone: ______________________

Have you ever had a blood transfusion? Yes / No What year?_______

Are you pregnant? No / Yes What week?____ Are you nursing No / Yes Are you taking birth control pills? No / Yes

Are you currently taking any medications, including over- the-counter, ie: Aspirin, Advil, Herbs, and/or Vitamins?
No / Yes, if so for describe what condition:

List: ____
____

In Case of an emergency who should be notified? Name:______________________________ **Phone**:_________________
Relationship to patient:_________________________________

It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and/or treatment.

____ Date: ______________________
Signature of patient, parent or guardian

Person Responsible For Payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ________________

Social Security #: ________________ Birth Date: ________________________________

Phone (Home): ________ (Work): ________________ Ext: ______ Cell: ____________________

Address: ____

Street Apartment #

____

City State Zip Code

OPTIONAL Credit Card Authorization

I authorize this office to charge my Credit Card for any outstanding balance due, that is considered delinquent by this office. I understand a delinquent account is any account that has no payment for 90 days.

Credit Card Number: ____

Circle One: MC Visa Discover AmEx Expiration Date__________ 3 digit security code________

Name on card: ______________________________ Signature ____________________________________

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/Phone: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

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 ☐ Other __________________

Insurance Plan Name and Address: ____

____

Consent for Services

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions whether manual or electronic.

I authorize the dentist to release all information necessary to secure payment of benefits.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services.

I have received a copy of the Notice of Privacy Practices of Michele S. Horton, D.D.S.,FAGD , PC and have been given an option to opt out.

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