Patient Information Form

Date _____ **Social Security #**_____ **Last dental exam** _____

Full Name _____ **E-Mail** _____

Preferred Name _____ **Date of Birth** _____ **Age**_____ **Sex**____

Address _____ **Apt#**_____ **City** _____ **St** ____ **Zip** _____

Married _____ **Single** _____ **Widowed** _____ **Divorced** _____

Home Phone (_____**)** _____ **Cell Phone (**_____**)** _____

Business Phone (_____**)** _____ **Business Name** _____

Referred By_____

INSURANCE

Do you have dental insurance? Yes _____ **No** _____

Name of Insured: _____

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____

Insured's Employer Name: _____

Insurance Co Name: _____ **ID #:** _____ **Group #:** _____

Insurance Co Address: _____

Consent for Services:

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

I understand that any fee estimate for this dental care can only be extended for a period of one year from the date of the patient examination. Other financial arrangements are available. Please ask the doctor or staff about these if you are interested.

_____I grant permission to you or your assignee to telephone me to discuss this statement or my treatment.

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

Consent to Leave Phone Messages/Release of Information

Paul K. Lonquist, D.D.S, M.A.G.D. has adopted a policy that requires our staff to obtain authorization from the patient to release and/or leave a detailed message for the patient. Secondary to the new HIPPA guidelines, we need to guard against violating any patient confidentiality and protect our staff. If we do not have assigned consent on file, we may only leave our name and phone number on the answering machine asking you to call back.

By completing the consent below, you authorize us to release information or leave a detailed message on voicemail or with a specific individual. In order for us to relate any of your medical information to anyone other than yourself, please indicate below.

I give my consent to Dr. Lonquist or his staff to release and/or leave messages regarding my care or lab results as necessary in the following situations.

_____home voice mail ____cell phone voicemail _____work voicemail _____with _____
(relationship) _____

_____ I do not consent to messages being left on any of the above phones.

_____ Date _____

Signature of patient, parent, or guardian (responsible party)

Patient Health/Medication Form

Name: _____ **Signature:** _____

Date: _____

General Health: _____excellent _____good _____fair _____poor

Physician's name: _____ **Phone:** _____

Pharmacy name: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Females: Are you pregnant? _____ **Due date:** _____ **If yes, doctor's name** _____

Please circle if you have ever been treated for any of the following: _____None

ADD/ADHD	epilepsy	High cholesterol	Periodontal disease
anemia	glaucoma	HIV	rheumatic fever
arthritis	hay fever	jaundice	sinus problems
asthma	heart disease	joint implant	skin cancer
bad breath	heart murmur	joint replacement	stroke
cancer	heart valve replacement	low blood pressure	thyroid
congenital heart lesions	hepatitis	lung disease	tuberculosis
diabetes	high blood pressure	mitral valve prolapse	ulcers

Other _____

Serious Illnesses _____

Hospitalizations/Surgeries _____
(use reverse side if needed)

Do/have you have/had: _____None

prolonged bleeding	gag easily	taken Phen Fen	snoring issues
fainting spells	grind teeth	concerns with smile/ look of teeth	excessive thirst
	pacemaker		excessive urination

Prescribed Medications you are taking	Medications you are allergic to
_____ None	_____ None
OTC Meds (Vitamins/Supplements)	**Other allergies**
_____ None	_____ None