Welcome to Frey Family Dentistry

Today's Date: _____

How did you hear about our office? _____

Email Address: _____

PATIENT INFORMATION

Name: _____
Last First M.I.
Address: _____
City,State,Zip: _____
Home Telephone: _____ Pager/Cell: _____
Work Telephone: _____ Employer: _____
Date of Birth: _____
Social Security: _____
D.L.# _____
Marital Status: _____ Spouse's Name: _____

GUARDIAN INFORMATION (If different)

Name: _____
Relationship to Patient: _____
Address: _____
City,State,Zip: _____
Home Telephone: _____ Pager/Cell: _____
Work Telephone: _____ Employer: _____
Date of Birth: _____
Social Security: _____
D.L.# _____
Marital Status: _____ Spouse's Name: _____

Terms of Account: We accept cash, VISA, Mastercard, Discover/Novus and American Express. Payment is expected at the time of service.
*Finance Charges: A monthly charge of **1.5% (18% yearly)** will be added to account balances more than **60 days** past due.*
*Cancellation Policy: We require a **24 hour** notice to cancel any scheduled appointment. Any **confirmed** appointment that is cancelled within 24 hours of the appointment may be assessed a **missed appointment fee**.*

Medical History

Are You Under The Care of A Physician? No/Yes: _____

_____

Have You Been Hospitalized in The Last 2 Years? No/Yes: _____

Currently Taking any Prescription Or Non-Prescription Medications: No/Yes: _____

_____

Are You Allergic Or Have You Had Adverse Reaction To Medications, Food, Or Other Substances Including: Penicillin ____ Codeine____ Latex____Rubber____Metal_____

Others, Please List _____

Dental History

Primary Reason For Your Visit Today? _____

Date Of Last Dental Visit _____ Procedures Done _____

Have you ever had? **(please circle)**

Oral/Maxillo Facial Surgery	Orthodontic Treatment	Periodontal or Gum Disease Treatment	TMJ Treatment

Additional Information Which Would Be Valuable For Us To Know: _____

_____

Have you ever had/do you have the following?

Dry Mouth	No Yes	_____
Rheumatic Fever	No Yes	_____
Heart Condition	No Yes	_____
Artificial Heart Valve	No Yes	_____
Joint Replacement	No Yes	_____
Rods, Pins, Screws?	No Yes	_____
Chemotherapy	No Yes	_____
Malignancy or Cancer	No Yes	_____
Radiation Therapy	No Yes	_____
Fainting Spells	No Yes	_____
High/Low Blood Pressure	No Yes	_____
Epilepsy/Seizure	No Yes	_____
Blood Disease	No Yes	_____
Anemia	No Yes	_____
Diabetes	No Yes	_____
Hepatitis	No Yes	_____
Cortisone Medications	No Yes	_____
Abnormal Bleeding	No Yes	_____
Tuberculosis	No Yes	_____
Positive HIV or AIDS	No Yes	_____
Eye or Retina Surgery	No Yes	_____
Asthma	No Yes	_____
Allergies	No Yes	_____
Currently Smoking	No Yes	_____
Ever smoke regularly?	No Yes	_____
Other Tobacco	No Yes	_____
Birth Control Pills	No Yes	_____
Are you Pregnant	No Yes	_____

Additional Medical Information: _____

Authorization And Release:

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Frey to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to Dr. Frey benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services rendered on my behalf.

Signature: _____
Patient (Parent or Guardian)

Examiner Notes: _____

_____

_____

_____

_____

Date	Initials	Update