Patient Information

Thank you for choosing Arte Dental for your dental care provider. Please complete as much of this form as possible. Thanks!

Name:____ Today's Date:___/___/______ Date of Birth: ___/___/_______

Address:____ City: _________________ State: _____ Zipcode: __________

Home Phone: ________________ Alternate Phone: ________________ Email:__________________________________

Emergency Contact Name: ______________________________ Emergency Contact Phone: ________________________

How did you hear about us?:____

Responsible Party (Parent or Insurance Primary Subscriber)

Name of person responsible for the account: _______________________________ Relation to patient: _______________

DOB:__________ Address:______________________________ City: _________________ State: _____ Zipcode: _________

Home Phone: ________________ Alternate Phone: ________________ Email:__________________________________

Dental Insurance Carrier: _____________________ PPO/DMO/Other: __________ Member ID: __________________

SS#: _______________ Group Number: ________________ Employer: __________________________________

Arte DENTAL

Dental History/Concerns

Date of last exam:__________ Former Dentist: ________________________ How often do you brush: ________________

How often do you floss: ___________ Any discomfort/bleeding when flossing: ______________ Bad Breath: _________

Would you like a whiter/brighter smile:______ Any pain or sensitivity:____

Medical History (please check any that apply)

__Pregnant
__Nursing
__Birth control
__AIDS/HIV
__Anemia
__Arthritis/ Rheumatism
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Back Problems
__Abnormal Bleeding
__Blood Disease
__Cancer
__Chemotherapy
__Circulatory Problems
__Cortisone Treatment
__Coughing
__ Diabetes
__Epilepsy
__Fainting
__Glaucoma
__Headaches
__Heart Problems
__Hepatitis
__High Blood Pressure
__Jaw Pain
__Kidney Disease
__Liver Disease
__Nervouse Problems
__Pacemaker
__Psychiatric Care
__Radiation Treatment
__Respiratory Issues
__Shortness of breath
__Stroke
__Swelling of feet/ankles
__Thyroid Problems
__Tobacco Use
__Tonsillitis
__Tuberculosis

Please list any current, or recent medications taken:____

List any known allergies:____

Any other medical issues that should be made known:____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. Once informed of the treatment plan, I agree to be financially responsible for all charges related to the treatment plan. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities when in connection with this claim. I hereby authorize and direct payment of the dental benefits, when applicable, otherwsie payable to Arte Dental. This consent will end once my current treatment plan has been completed or three years from the date below.

Signature of Patient, Parent or Guardian:____ Date: ______________

Printed Name of Patient, Parent or Guardian:________________________________ Relation to Patient: ____________