Samuel J. Holcroft, D.M.D., P.A

Patient Information: **Date: _____**

Last Name_____ First_____ Middle Initial_____

Address_____City_____St_____Zip_____

Home Phone (_____) _____ Cell (_____) _____

Email_____ Reminder: Text _____ Email _____ Phone Call _____

Date of birth _____SS#_____- _____ -_____ Driver's License_____

Sex: Male____ Female____ Marital Status: Single ___ Married ___ Divorced ____ Widow___

Employer_____Occupation_____

Pharmacy: _____Location_____Phone_____

Referred By: _____

Responsible Party: (Spouse or Parent) If applicable

Last Name _____ First_____ Middle Initial_____

Address_____City_____St_____Zip_____

Home Phone (_____) _____ Cell (_____) _____

Email_____ Relationship_____

Date of birth _____SS#_____-_____-_____ Driver's License_____

Medical History:

Physician: _____ Phone #_____

Date of last exam_____

History of excessive bleeding requiring special treatment? Y _____ N _____

If yes, explain: _____

List all medications, purpose & dosage below: **Check here for none**_____

1)_____

2)_____

3)_____

4)_____

Are you **Allergic** to or have you had a reaction to any of the following?

Local Anesthesia (e.g. Novocain): Y_____N_____

Codeine/Sedatives/Sleeping Pills/Narcotic: Y_____N_____

Penicillin? Other Antibiotics: Y___ N___ If other, please list: _____

Aspirin: Y____N____ Sulfa Drugs: Y____N____ Other Allergies: _____

Women only: Are you pregnant? Y____ N____ Due Date_____ Nursing Y___N____

Are you taking birth control pills? Y____N____ (antibiotics make birth control pills ineffective)

Office Policies and Financial Responsibilities

PAYMENTS are due at the time of treatment. For your convenience, we offer the following payment arrangements: Cash, Personal Checks, Money Orders, Visa, MasterCard, American Express, Discover, and Care Credit. A RETURNED CHECK FEE OF $35.00 will be charged to the account for any check is returned for insufficient funds

INSURANCE claims are filed for you as a courtesy. Dental insurance is a contract between you and your insurance carrier. Our goal is to help you maximize insurance benefits available, so we can assist you in making excellent dentistry affordable. We base our ESTIMATES on the information we receive from your insurance plan. You will be responsible for the ESTIMATED patient part plus a deductible, if applicable, at the time of service. If there are any changes in your plan or coverage, it is your responsibility to provide the information PRIOR to being seen. If for any reason any claim is denied / and or unpaid the patient/guarantor is responsible for those charges.

CANCELLATIONS are a pain for everyone. Please understand we have reserved appointment time just for you. We schedule hygiene appointments up to 6 months in advance. We highly recommend this to assure you get an appointment time that will meet your scheduling needs. We realize on occasion, that things may arise to keep you away. We ask that you notify us as soon as possible, but no later than 48 hours in advance of the appointment to avoid a **$100** charge to your account.

DELINQUENT ACCOUNTS will be subject to collection activities and all information will be sent to all major CREDIT AGENCIES. You will be responsible for all fees and charges applicable by law. Any account overdue by 30 days will receive a monthly billing fee, UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.

I certify that I am the patient or authorized general agent of the patient. I have read and fully understand my financial responsibilities under this policy.

Patients Name(print) _____ Date of Birth _____

Patient/ Guarantor Signature _____ Date _____

Medical History

Do you have or have you had any of the following? Please Circle Answer

Heart Disease/Attack/Surgery	Y N	Tumors/ Growths	Y N
Angina	Y N	Cancer	Y N
High Blood Pressure	Y N	Radiation/ Chemotherapy	Y N
Artificial Heart Valves	Y N	Athritis	Y N
Heart Pacemaker	Y N	Glaucoma	Y N
Artificial Joints	Y N	H IV / AIDS	Y N
Pre-medicate for Dental Trtmt?	Y N	Hepatitis A, B, C	Y N
Stroke	Y N	Liver Disease	Y N
Kidney Problems	Y N	Alcoholism	Y N
C.O.P.D.	Y N	Drug Addiction	Y N
Tuberculosis (T B)	Y N	Hemophilia	Y N
Asthma	Y N	Cold Sores	Y N
Diabetes	Y N	Epilepsy or seizures	Y N
Sickle Cell Disease	Y N	Thyroid Disease	Y N

Is there any disease , condition or problem you have that we should be aware of? Is there any activity your doctor said you could not or should not do? Explain _____

Reason for this visit? _____ Last Dental APPT? _____

Does dental treatment make you nervous? Please circle No Slightly Moderately Extremely

Treated for Periodontal Disease (Gum Disease, Pyorrhea, Trench Mouth)? Y N

Please **Underline** if Applicable : Bleeding/sore gums, Bad Breath/ Taste, Burning tongue/Lips, Blisters on Lips/Mouth, Swelling/ Lumps in Mouth,Biting Lips/ Cheeks, Loose Teeth, Sensitive to Heat/ Cold/Sweets/ Biting, Packing Food Between Teeth, Clenching/ Grinding, Smoker

I have completed this for to the best of my ability. I am the patient or the patients authorized agent/guardian and am qualified to answer these questions.

Signature of Patient (or Parent or Guardian if patient is a minor) _____ Date _____

Dentists Signature _____ Date