TOWN SQUARE DENTAL
JOSHUA NEUMAN, DDS

Patient Information (confidential)

Name _____ Birth date ____/____/____ SS#_____

Physical Address _____City _____State _____ Zip _____

Billing Address_____City_____State_____Zip_____

Home Phone (____)_____ Cell Phone (____)_____ Email _____

Circle: minor single married divorced widowed separated

Occupation _____ if Student, Name of School _____

Circle: full time part time

Patient's Employer _____Work Phone (____)_____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian name _____Employer_____

Work Phone (____)_____ whom may we thank for referring you? _____

Emergency Contact Name: _____ Phone number : _____ Relation: ____

Pharmacy Name: _____ Phone Number: _____

Responsible Party

Name of Person Responsible for this account _____

Relation _____ Birth date ____/____/____ Driver's License # _____

Address _____ City_____ State_____ Zip_____

Home Phone (____)_____ Cell Phone (____)_____

Employer _____ Work Phone (____)_____

Is this person currently a patient in our office? *Yes* *No* For your convenience, we offer the following methods of payment. Please circle the option you prefer.

Cash *Personal Check* *Discover/ MasterCard/ Visa* *Care Credit*

Payment is expected in full at each appointment.

Dental Insurance Information

Name of insured _____ Relation _____

Birth date ____/____/____ SS# _____ Name of Employer _____

Address _____ City _____ State_____ Zip _____

Work Phone (____)_____ Insurance Company _____ Group # _____

Do you have any additional **dental** insurance? *Yes* *No* If yes, complete the following:

Name of insured _____ Relation _____

Birth date ____/____/____ SS# _____ Name of Employer _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Communication Preferences

Patient Name _____Date of Birth _____

Town Square Dental may communicate with me through the following methods:

□ Automated Appointment Reminder System via Text. Cell Number _____

□ Phone Call and Voice Message. Phone Number(s)_____

□ Phone Call and No Voice Message. Phone Number(s) _____

□ Email Address_____

□ Other _____

□ I do not wish to receive any contact from Town Square Dental via phone call, voicemail, text, or email. I understand that if I miss a scheduled appointment, I will be charged a Broken appointment fee of $100.00

How may we contact you? _____

I hereby give consent to Town Square Dental to disclose Protected Health Information (PHI) to the following individuals:

Name: _____Relationship: _____

Name:_____ Relationship: _____

Name: _____Relationship: _____

□ I understand that I have the right to revoke this consent, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

□ I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this consent.

Patient/Guardian Signature _____ Date _____

Patient Health History

Patient Name _____ Date of Birth _____

Welcome to our office! Please fill out this detailed medical history so we are aware of any problems you may have or have had in the past. If there is anything medically NOT listed on this form, please use the "Additional comments" section to write in any other information. Thank you.

Primary reason for this appointment_____

Name of your Physician(s) _____

Physician(s) phone numbers _____

Date of last visit to physician(s) _____

Are you in good health? _____

Have you EVER been hospitalized or had any surgeries? If so, list for what and dates._____

_____

_____

Are you taking any prescriptions (including over the counter) If so, please list them and what you are taking them for _____

_____

_____

Do you currently have or have you had any of the following in the past?

1. Damaged Heart Valves, artificial valves or heart murmur? ..... Yes NO
2. Rheumatic Heart Disease..... Yes NO
3. Arteriosclerosis ..... Yes NO
4. High blood pressure ..... Yes NO
5. Heart trouble, heart attack, angina, or any other heart related condition ..... Yes NO
6. Chest pain on exertion ..... Yes NO
7. Shortness of breath after mild exercise ..... Yes NO
8. Do your ankles swell ..... Yes NO
9. Allergies to foods, plants, latex, etc ..... Yes NO

   Please list _____

   _____

10. Sinus trouble ..... Yes NO
11. Asthma or hay fever ..... Yes NO

12. Fainting spells or seizures ..... Yes NO

13. Diabetes ..... Yes NO
14. Hepatitis, jaundice or liver disease ..... Yes NO
15. Frequent or reoccurring mouth sores ..... Yes NO
16. Thyroid problems ..... Yes NO
17. Respiratory problems ..... Yes NO
18. Arthritis or painful/swollen joints ..... Yes NO
19. Stomach ulcer or hyperacidity ..... Yes NO
20. Kidney trouble ..... Yes NO
21. Tuberculosis ..... Yes NO
22. Persistent couch or cough that produces blood ..... Yes NO
23. Persistent swollen neck glands ..... Yes NO
24. Epilepsy or neurological disorder ..... Yes NO
25. Problems with mental health ..... Yes NO
26. Cancer ..... Yes NO
27. Compromised immune system ..... Yes NO
28. Glaucoma ..... Yes NO
29. Joint replacement ..... Yes NO
30. Osteoporosis ..... Yes NO
31. HIV Virus/ AIDS ..... Yes NO
32. Any abnormal bleeding ..... Yes NO
33. Have you ever had a blood transfusion ..... Yes NO
34. Anemia or other blood disorder ..... Yes NO
35. Have you ever had treatment for a tumor or growth ..... Yes NO

Are you allergic or have you had a reaction to:

Local Anesthetics ..... Yes NO
Penicillin or antibiotics ..... Yes NO
Sulfa drugs ..... Yes NO
Barbiturates or sleeping medication ..... Yes NO
Aspirin ..... Yes NO
Iodine ..... Yes NO
Codeine or other narcotics ..... Yes NO

Other medical condition not listed above, please list _____

_____

_____

Do you now or have you ever used tobacco products ..... Yes NO

Have you ever had complications with previous dental treatment ..... Yes NO

If yes, please explain _____

Do you wear contact lenses ..... Yes NO

Are you wearing removable dental appliances ..... Yes NO

Do you snore at night? Yes NO

Do you use a CPAP Yes NO

Was it ever recommended to use a CPAP at night? Yes NO

Has anyone ever told you that you snore? Yes NO

Women:

Are you pregnant ..... Yes NO

Are you nursing ..... Yes NO

Additional comments _____

_____

_____

Additional questions you have for the dentist _____

_____

48 Business hours notice is required to cancel or change an appointment. If proper notice is not given, unless in an emergency situation, a $100 fee will be charged.

Balance is due at the time service is rendered unless previous payment arrangements have been made. Our office is happy to file with your Insurance as a courtesy, and we strive to assist you in maximizing the most of your benefits available to you. Should for any reason Insurance not submit payment or a procedure is denied, it is ultimately the patient's responsibility. Insurance companies are not always accurate and do not guarantee payment or availability of benefits when we receive a breakdown of your benefits. This breakdown is where we obtain the information to provide you with a pre treatment estimate. Any remaining balance or denial from Insurance is between the patient and your Insurance company.

_____

Signature of Patient or Guardian

I certify that I have read and understand the above information and have been as thorough as possible. I have accurately answered all questions correctly to the best of my knowledge. I understand that providing false information could be dangerous to my health. I will not hold my dentist or any staff member responsible for an error or omission that I may have made in completing this document.

_____ _____ _____

Print Patient Name Signature of patient or guardian Date