Confidential Information Form

Patient

❑ Mr. ❑ Mrs. ❑ Miss ❑ Dr. ❑ Minor Date: _____

First Name: _____ M.I. _____ Last Name: _____

Address_____City _____State _____ Zip_____

Email_____ Phone (_____)_____Cell (_____)_____

Patient Information

Sex M F Age _____ Date of Birth ____/____/____

DL #:_____State_____ Marital Status:_____Weight____Height_____

Employer's Name_____Work Phone # (_____)_____

Employer's Address:_____

If student, School:_____Grade:_____

Person to contact for emergency _____Phone # (_____)_____

Spouse or Responible Party

Person responsible for account:_____

Relationship to Patient_____

Address (if different)_____ Phone (____) _____

Name of Employer_____Work Phone # (____) _____

SS #____-___-_____D.L. #_____State_____DOB_____

Insurance

Primary Insurance Co._____

Name of Insured_____

Group Policy #_____

Employer_____

SS # ___-___-_____ Birth Date _____

Relationship to Patient_____

Secondary Insurance Co._____

Name of Insured_____

Group Policy #_____

Employer_____

SS # ___-___-_____ Birth Date _____

Relationship to Patient_____

Who may we thank for referring you:_____

Dentist_____Physician_____

What is the reason for your visit today? _____

_____

List any medications you are currently taking: _____

May we have permission to use any models and/or photos pertaining to treatment for professional display. _____Initial

Do you have an Advanced Directive? YES_____ or NO_____
Please be aware that it is our policy that Advanced Directives for "do not resuscitate" are not honored at this facility.

Circle any of the following that you are allergic to:

Penicillin	Tetracycline	Nitrous Oxide	Epinephrine	Barbiturates	Aspirin
Iodine	Xylocaine	Local Anesthesia	Percodan	Morphine	Keflex
Novocaine	Atropine	Codeine	Latex	Dermerol	Valium
Brevital	Erythromycin	Tylenol	Sulfa Drugs	Pentothal	Percocet

Other: _____

Describe any illness for which you are being treated _____

_____

GRIEVANCE POLICY

Patients should notify the medical director in writing of any concerns or complaints or disagreement about care decision between the patient and care provider.

Your use of tobacco: ❑ None ❑ Cigarette ❑ Cigars ❑Pipe ❑ Chew/Snuff How long? _____Packs daily _____

Your level of alcohol consumption: ❑ None ❑ Light ❑ Moderate ❑ Heavy How long? _____

Women

Are you pregnant? ❑Yes ❑ No Are you taking birth control pills? ❑ Yes ❑ No

Circle any of the following that you have had or currently have:

Hepatitis	Lung Disease	Heart Attack	Heart Disease	Asthma
Heart Murmur	Ulcers	High Blood Pressure	Diabetes	Glaucoma
Thyroid Disease	Stroke	Rheumatic Fever	Excessive Bleeding	Chest Pain
Kidney Disease	Dialysis	Psychiatric Treatment	Excessive Bruising	Blood transfusions
Artificial Heart Valve	Seizures	Blood Disease		

Are you currently under medical treatment other than above? ❑Yes ❑ No _____

CONSENT/AUTHORIZATION

The undersigned hereby authorize and consent to X-rays, study models, photographs, medications or any other diagnostic aids deemed necessary for treatment by the attending Physician to aid in a thorough diagnosis of the patient's dental needs.
I (we) hereby assign insurance benefits to Dr. Michael P. Morrissette and Dr. David L. Baker. I (we) further authorize Dr. Morrissette and Dr. Baker to employ such assistance as deemed fit. I (we) understand that responsibility for payment of services provided in this office for my myself or said patient, is due and payable at the time services are rendered unless prior financial arrangements have been made. I (we) further understand that a 3.5% finance charge (29.95% annually) will be added to any balance over 60 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I have read and understand the above.

How will you be taking care of your balance today? CASH ❑ CHECK ❑ CHARGE ❑

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO DR. MORRISETTE & DR. BAKER FOR ALL CARE AND SERVICES PROVIDED TO ME AND/OR MY DEPENDENTS.

Name of Responsible Party_____Relationship to Patient_____
(PRINT) (PRINT)

Signature of Responsible Party_____Witness_____