Patient Intake Form

BONITA Medical Center

PATIENT INFORMATION

DATE:

Last Name _____ First _____ Middle Initial _____

Birthdate _____ Age _____ Marital Status _____ SS# _____

Address _____ City _____

State _____ Zip _____ Email _____

Home Phone _____ Cell _____ Referred by _____

Reason For Visit _____

ACCOUNT INFORMATION

Person Responsible for Account _____ Relationship _____

SS# _____ Email _____ DOB _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell _____

Occupation _____ Employer _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name of Insured _____ DOB _____ SS# _____

Relationship to Patient _____ Sex _____ Employer _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name of Insured _____ DOB _____ SS# _____

Relationship to Patient _____ Sex _____ Employer _____

MEDICAL HISTORY

It is important to provide accurate information to ensure a safe and successful surgery/procedure.

1. Are you in good health? ☐ Y ☐ N
2. Has there been any change in your general health in the past year? ☐ Y ☐ N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ☐ Y ☐ N
5. Have you ever had any serious illness, surgery or hospitalization? ☐ Y ☐ N

   If so, describe: _____

   _____

6. Do you have or have you ever had:
   - A. Rheumatic Fever or Rheumatic Disease? ☐ Y ☐ N
   - B. Congenital Heart Disease? ☐ Y ☐ N
   - C. Kidney Disease? ☐ Y ☐ N
   - D. Diabetes? ☐ Y ☐ N
   - E. Thyroid Disease (Goiter)? ☐ Y ☐ N
   - F. Arthritis? ☐ Y ☐ N
   - G. Stomach Ulcers or Colitis? ☐ Y ☐ N
   - H. Glaucoma? ☐ Y ☐ N
   - I. Osteoporosis? ☐ Y ☐ N
   - J. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ☐ Y ☐ N
   - K. Sinus or Nasal problems? ☐ Y ☐ N
   - L. Any disease, drug or transplant operation that has depressed your immune system? ☐ Y ☐ N
7. Do you have or have you ever had **(Circle All That Apply)**
   - A. Cardiovascular Disease: Heart Attack, Heart Trouble, Heart Murmur, Angina, Stroke, Coronary Artery Disease, High Blood Pressure, Palpitations, Heart Surgery, Pacemaker ☐ Y ☐ N
   - B. Lung Disease: Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing ☐ Y ☐ N
   - C. Seizures, Convulsions, Epilepsy, Fainting, Dizziness ☐ Y ☐ N
   - D. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Bruise Easily ☐ Y ☐ N
   - E. Liver Disease: Jaundice, Hepatitis ☐ Y ☐ N
   - F. Radiation from X-ray, Cancer Treatment Radiation ☐ Y ☐ N
   - G. Clicking or Popping of Jaw Joint, Pain Near Ear, Difficulty Opening Mouth, Grind or Clench Teeth ☐ Y ☐ N
8. Are you using any of the following?
   - A. Antibiotics? ☐ Y ☐ N
   - B. Anticoagulants (Blood Thinners)? ☐ Y ☐ N
   - C. Aspirin, Ibuprofen, Acetometaphin or other over-the-counter pain relievers? ☐ Y ☐ N
   - D. High Blood Pressure medications? ☐ Y ☐ N
   - E. Steroids (Cortisone, Prednisone, etc.)? ☐ Y ☐ N
   - F. Tranquilizers? ☐ Y ☐ N
   - G. Insulin or Oral Anti-Diabetic drugs? ☐ Y ☐ N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? ☐ Y ☐ N
   - I. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers: Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa? ☐ Y ☐ N
   - J. Are you currently taking any antidepressant or anxiety medication? ☐ Y ☐ N

9. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins, or minerals.

10. Are you allergic to or have you have an adverse reaction to:
    - A. Local Anesthesia (Novacain, etc.)? ☐ Y ☐ N
    - B. Penicillin or other antibiotics? ☐ Y ☐ N
    - D. Aspirin or Ibuprofen? ☐ Y ☐ N
    - E. Codeine or other pain killers? ☐ Y ☐ N
    - F. Latex or Rubber products? ☐ Y ☐ N
    - G. Metal of any kind? ☐ Y ☐ N
    - I. Food products? ☐ Y ☐ N
    - J. Other allergies or reactions? Please list: ☐ Y ☐ N

11. Do you smoke or chew Tobacco? ☐ Y ☐ N
12. Is there any personal or family history of Alcohol, Chemical Dependency? ☐ Y ☐ N
13. Have you had any problems associated with any previous dental treatment? ☐ Y ☐ N
14. Describe any disease, condition or problem not listed above.

15. Have you ever had a bone density scan? ☐ Y ☐ N
16. Are you pregnant, or is there any chance you might be pregnant? ☐ Y ☐ N
17. Are you nursing? ☐ Y ☐ N
18. Are you are using Oral Contraceptives? ☐ Y ☐ N
19. Have you had an HIV Bloodtest? ☐ Y ☐ N
20. Have you ever had Hepatitis A, B, or C? ☐ Y ☐ N

FINANCIAL RESPONSIBILITY

Patients are responsible for full payment at the time of service. We accept cash, checks and all major credit cards. Minors accompanied or unaccompanied are responsible for full payment at the time of service. Non emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or a major credit card.

If your insurance plan is accepted at Bonita Medical Center, you must pay at least 40% of total charges at time of service (some procedures require 50% payment), if your insurance has not paid the full balance within 45 days you will need to pay the balance within fifteen business days. A 1.5% finance charged will be added to all past due accounts.

Insurance coverage is a contract between you and your provider. We file insurance claims as a courtesy to our patients. Bonita Medical Center will not be involved in disputes of any kind with your insurance company. However we will be happy to supply factual information as needed. Bonita Medical Center is a non-participating Medicare/Medicaid provider.

There is a $100.00 charge for missed appointments and cancellations with less that 24 hour notice.

I understand that it is my responsibility to fill out this form completely and correctly. I have provided accurate information and assume financial responsibility for all services rendered.

Signature of Responsible Party

Date

FOR COMPLETION BY SURGEON:

Comments on patient interview concerning medical history:

Significant findings from questions or oral interview:

Surgeon's Signature

Date