# MARC A. PANET-RAYMOND DDS PC – TRANSFORM DENTAL

## PATIENT RECORD

Patient Name: _____ Today's Date: _____

Current Address _____

Patient Home Phone: _____ Work Phone: _____ Cell: _____

Marital Status: M__ S__ D__ W__ Patient Birthdate: _____ Patient SSN: _____

**Email**_____

## MEDICAL HEALTH

Name of Physician:_____ Date of Last Check Up:_____

Have there been any changes in your general health in the past year? Yes [ ] No [ ]

Do you use tobacco?..... Yes [ ] No [ ]

*Has your physician ever indicated that you need to have antibiotic pre-medication prior to dental treatment?Yes [ ] No [ ]*

PLEASE LIST MEDICATIONS THAT YOU ARE TAKING

_____ Purpose:_____ _____ Purpose:

_____ Purpose:_____ _____ Purpose:

**FEMALES: Are you pregnant? Yes [ ] No [ ] Are you taking contraceptives? Yes [ ] No [ ]**

**Have you ever been treated for:**

| | | |
|---|---|---|
| Hip or other joint replacement..... Yes [ ] No [ ] | Diabetes..... Yes [ ] No [ ] | Rheumatic fever..... Yes [ ] No[ ] |
| Abnormal blood pressure.....Yes [ ] No [ ] | HIV (AIDS)..... Yes [ ] No [ ] | Epilepsy.....Yes [ ] No[ ] |
| Tuberculosis or Lung Disease..... Yes [ ] No [ ] | Hepatitis..... Yes [ ] No [ ] | Arthritis.....Yes [ ] No[ ] |
| Congenital Heart Disease..... Yes [ ] No [ ] | Cancer..... Yes [ ] No [ ] | Stroke.....Yes [ ] No[ ] |
| Asthma or Hay Fever..... Yes [ ] No [ ] | Sinus trouble..... Yes [ ] No [ ] | Ulcers.....Yes [ ] No[ ] |
| Mitral Valve Prolapse..... Yes [ ] No [ ] | Heart Murmur..... Yes [ ] No [ ] | Fainting Spells.....Yes [ ] No [ ] |
| Prolonged bleeding..... Yes [ ] No [ ] | High Cholesterol..... Yes [ ] No [ ] | Thyroid problems.....Yes [ ] No [ ] |

**Are you allergic to: Codeine [ ] Penicillin [ ] Local injections [ ] Aspirin [ ] Sulfa [ ] Latex [ ]**

Allergic to any other substance?

***Please turn to next page***

*(Office Use) [_____] [_____]*

*[_____] [_____]*

*[_____] [_____]*



PATIENT AND INSURANCE INFORMATION

Patient's Name: _____

Patient's Employer: _____ Occupation or Job Title:

[ ] Full Time Student, Where:_____

**********

**Insurance Holder Information:**

Insured's Name: _____ Birthdate:

Insured's SSN: _____ Relationship to Patient: [ ] Self [ ] Other

Employer: _____ Work Phone: (_____)

**Insurance Company** (to be billed): _____ Group #:

Insured's Ins. ID#_____

**********

**Secondary Insurance:**

Insured's Name: _____ Birthdate:

Insured's SSN: _____ **Insured's Employer:**

**Insurance Company:** _____ Group #:

Insured's Ins. ID#

**********

EMERGENCY CONTACT PERSON: Name: _____Phone:

*Did someone refer you to our office? Name:*

**Cancellation Policy**

When you make an appointment with our office, time is reserved in the doctor's or hygienist's schedule to see you or your family member. If you miss your appointment or cancel too late, we are not able to use the time to see another patient. We now require **at least 48 hours to cancel or reschedule an appointment.** Because our office is closed on Fridays, patients wanting to cancel or reschedule a Monday appointment should do so by the previous Thursday.

A charge may be assessed for a late cancellation or missed appointment. Insurance will ***not*** cover these charges. An advance payment may be required of new patients or those who have missed or cancelled without the required notice. Please note that your insurance will not cover these advance payments if the treatment is not completed.

We appreciate our patients and strive to see each one promptly at the reserved time. Thanks in advance for your compliance with this policy.

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand that providing incorrect information may be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of a treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners in accordance with this office's Privacy Practices. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X**_____ **Date**

**Signature of Patient or Parent/Guardian, if minor**