Bastien DENTAL CARE
Richard J-P Bastien, DMD

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PATIENT INFORMATION

Name _____ Nickname _____
First Middle Last

Date of Birth _____ Social Security Number_____Age ____Sex _____

Lives with _____ Marital Status _____

Address _____
Number & Street City State Zip

Home Phone _____ Work Phone _____ Place of Employment _____

Cell Phone/Pager _____ Email Address _____

INSURANCE INFORMATION

Name of Dental Insurance Company: _____Phone: _____

Claims Mailing Address: _____

Name of Card Holder: _____Social Security #:_____

Date of Birth_____Group#: _____ID#: _____

Relationship to Card Holder Self Spouse Child

MEDICAL INFORMATION

In the following questions, circle "yes" or "no", whichever applies. Your answers are for you and will be considered confidential.

Are you currently under the care of a physician? Name _____Phone # _____

Are you taking any medications, prescribed or not prescribed? Please list _____Yes No

_____

Have you ever had any serious illness or operations? Please explain _____Yes No

Do you have any allergies to the following substances:

__**Penicillin** __**Codeine** __**Acrylic** __**Latex** __**Metal** __**Other** _____Yes No

Have you ever had any of the following:

Rheumatic fever, Heart Murmur, Mitral Valve Prolapsed, Heart Surgery or **Joint replacement?** Yes No

Have you had a **tumor** or **cancer** and received chemotherapy, x-tray, radium, or cobalt treatments for it? Yes No

Have you ever had any **reaction to any anesthetic?** If yes, please explain Yes No

Have you had any injury to your face or jaw? Yes No

WOMEN: Are you currently pregnant or trying to get Pregnant?__Yes _____No

PLEASE TURN OVER

Do you have or have you had any of the following diseases or problems:

High or low blood pressure	Yes	No	Glaucoma	Yes	No
Sinus trouble or hay fever	Yes	No	Sexually transmitted disease	Yes	No
Asthma	Yes	No	Persistent Cough	Yes	No
Fainting spells or seizures	Yes	No	Tuberculosis	Yes	No
Emotional or psychiatric problems	Yes	No	Stomach ulcers	Yes	No
Hepatitis A, B, or C, jaundice or liver disease	Yes	No	Kidney Trouble	Yes	No
Alcohol or drug addiction	Yes	No	Arthritis	Yes	No
High or low thyroid symptom	Yes	No	Diabetes	Yes	No
Canker sores or Cold sores	Yes	No	Blood disorder (Anemia) (Or excessive bleeding)	Yes	No

DENTAL INFORMATION

Name of previous Dentist _____ Date of last dental cleaning and exam _____

Are you having any dental problems at this time?	Yes	No
Date of last full mouth set of x-rays? (Series of 18 individual films)		
Do you ever experience any bleeding when brushing or flossing your teeth?	Yes	No
Have you ever had a previous bad experience at a dental office before?	Yes	No
Do you like the appearance of your teeth?	Yes	No
Do you feel you might have problems keeping your breath fresh?	Yes	No
Is there anything you would like to change about your smile?	Yes	No

I certify that the above information is true and accurate, and that there have been no omissions from my medical history. I understand this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes. I authorize the dental staff to perform any necessary dental services with my informed consent. I authorize the release of any medical or other information necessary to process insurance claims and authorize payment of benefits to the treating physician/dentist for the services provided. **I agree to be financially responsible for all services rendered and that payment for services rendered is due the day of my appointment.** I understand that as a courtesy to me my insurance company will be billed. I understand that I am responsible for any charges that occur even in the event insurance does not cover the treatment.

In the event that patient/undersigned is financially responsible for dental services rendered to patient by Dr. Bastien and the patient or undersigned fails to pay within 30 days from the due date, Dr. Bastien may refer the account to an attorney or collection agency for recovery of the sums due to Dr. Bastien. In that event, Dr. Bastien shall be entitled to recover reasonable attorney's fees and costs of collection.

The undersigned acknowledges that they have read and fully understand the foregoing disclosure and agree to be bound by the obligations hereunder and consent to the authorizations described above.

Signed _____ Date _____

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