HORTON & VRANAS D.D.S.

Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Name Of Minor/Child: ____ **Date**:_______________
Last First MI (Preferred Name)
Gender: ☐ M ☐ F **Age**:____ **Birthdate**:___________ **Family Status**:______________**SocialSecurity#**:__________________
Hobbies:____Referred by:____

Phone Home: _______________ **Parent/Guardian Name**:___________________________ **Cell**: ___________________________
Preferred Confirmation Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail ☐ Text Msg

Address:____**EMailAddress**:______________________________
Street

____
City State Zip
Emergency Contact Information:_______________________**Relationship**:_____________**Phone**:_____________

Health Information

Has Minor/Child had any history of or difficulty with any of the following? Please check those that apply:

☐ Artificial Heart Valves
☐ Artificial Joints
PlaceDate:_____________
Type______________

☐ AIDS/HIV
☐ Asthma
☐ Cancer
Type________Year____
Chemo______
Radiation_____
☐ Diabetes DietControlled_
Insulin Dependant___
☐ Anemia

☐ Epilepsy/Seizures
☐ Convulsions
☐ Fainting/Dizziness
☐ Heart Problems
☐ Cardiac Stent/Year__
☐ Heart Murmur
☐ Bladder Problems
☐ Cerebral Palsy
☐ Hepatitis
☐ Measles
☐ Mumps
☐ Tuberculosis
☐ Sinus Problems
☐ Mononucleosis

☐ Blood Disease
☐ Drug/Alcohol Abuse
☐ Hearing Problems
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Problems
☐ Psychiatric Care
☐ Stroke
☐ Ulcers
☐ Other
☐ ________
☐ ________
☐ ________
☐ ________

Allergies
☐ Amoxicillin Allergy
☐ Aspirin Allergy
☐ Codeine Allergy
☐ Dental Anesthetics
☐ Latex Allergy
☐ Penicillin Allergy
☐ Tetracycline Allergy
☐ Sulfa Drug Allergy
☐ Other Drug Allergies

- Minor/Child's Physician:__________________________Phone:__________________ Date of Last Physical Exam __________________ Results:__________________ Is Minor/Child under care of physician now? ☐ Yes ☐No
- If so for what condition(s):____

- Receiving any medication or drug(s)? ☐ Yes ☐ No Ever been hospitalized? ☐ Yes ☐ No Ever had surgery? ☐ Yes ☐ No
Medications:____

Dental History

Date of last visit to dentist:_________________ For What Service:_____________________________
Has your child complained about dental problems? ☐ Yes ☐ No Do you drink well water/ city water / well water? **Circle One**

Does your child brush teeth daily? ☐ Yes ☐ No Have you ever had your water tested for fluoride? ☐ Yes ☐ No

Does your child floss every day? ☐ Yes ☐ No Is fluoride taken in any form? ☐ Yes ☐ No

Any injuries to the mouth, teeth, head? ☐ Yes ☐ No Any unhappy dental experiences? ☐ Yes ☐ No

Any mouth habits-thumbsucking,nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ Yes ☐ No

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child that may be needed during diagnosis and/or treatment.

____ Date: ______________________
Signature of patient, parent or guardian

Person Responsible For Payment

Name: ____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ____________________

Social Security #: _______________ Birth Date: ______________________________

Phone Home: ______________ Work: ___________ Ext: _______ Cell: ____________________

Address: ____
Street Apartment #

____
City State Zip Code

Credit Card Authorization

I authorize this office to charge my Credit Card for any outstanding balance due, that is considered delinquent by this office. I understand a delinquent account is any account that has no payment for 90 days.

Credit Card Number:______________________________________

Circle One: MC Visa Discover AmEx Expiration Date__________3 digit security code________

Name on card:______________________________ Signature____________________________________

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Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _______________ ID #: __________________ Group #: __________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name/Phone: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _______________ ID #: __________________ Group #: __________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Insurance Plan Name and Address: ____

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Consent for Services

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions whether manual or electronic.

I authorize the dentist to release all information necessary to secure payment of benefits.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

It is my responsibility to inform this office of any changes the medical status of my minor/child. I authorize the dental staff to perform any necessary dental services that my minor/child may need during diagnosis and/or treatment.

I have received a copy of the Notice of Privacy Practices of Michele S. Horton, D.D.S.,FAGD , PC and have been given an option to opt out.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ____________ Relationship to Patient: __________________
Signature of patient, parent or guardian

____ Date: ____________ Relationship to Patient: __________________
Signature of guarantor of payment/responsible party