William F. Pochal, DDS, MD **Daniel H. Farr, MS, DDS, MD** **Matthew B. Brown, DDS, MD**

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P A T I E N T   I N F O R M A T I O N

PREFIX FIRST NAME MI LAST NAME SUFFIX		I LIKE TO BE CALLED	SEX M _____ F_____
STREET ADDRESS	DATE OF BIRTH	HOME PHONE NUMBER	
CITY, STATE, ZIP CODE	CELL PHONE NUMBER		
EMPLOYER (IF STUDENT, NAME OF SCHOOL)	WORK PHONE NUMBER EXT.		
REFERRED BY	NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY		
PHARMACY NAME AND LOCATION	RELATIONSHIP	PHONE NUMBER	

PERSON RESPONSIBLE FOR ACCOUNT

FIRST NAME MI LAST NAME	
RELATIONSHIP TO PATIENT	HOME PHONE
STREET ADDRESS	
CITY, STATE, ZIP CODE	
DATE OF BIRTH	EMPLOYER
CELL PHONE	WORK PHONE EXT.

INSURANCE HOLDERS INFORMATION

FIRST NAME MI LAST NAME	
RELATIONSHIP TO PATIENT	HOME PHONE
STREET ADDRESS	
CITY, STATE, ZIP CODE	
DATE OF BIRTH	EMPLOYER
CELL PHONE	WORK PHONE EXT.

I N S U R A N C E   I N F O R M A T I O N

D E N T A L INSURANCE		M E D I C A L INSURANCE	
P R I M A R Y	**S E C O N D A R Y**	**P R I M A R Y**	**S E C O N D A R Y**
POLICYHOLDER NAME	POLICYHOLDER NAME	POLICYHOLDER NAME	POLICYHOLDER NAME
INSURANCE COMPANY	INSURANCE COMPANY	INSURANCE COMPANY	INSURANCE COMPANY
INSURANCE ID #	INSURANCE ID #	INSURANCE ID #	INSURANCE ID#
GROUP #	GROUP #	GROUP #	GROUP #
INSURANCE ADDRESS	INSURANCE ADDRESS	INSURANCE ADDRESS	INSURANCE ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE

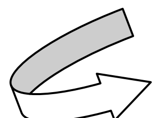
ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above. I will forward all insurance benefits, if any, to Dr. Pochal, Dr. Farr, or Dr. Brown that are made payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

______________________________ ______________________________ ____________________

Responsible Party Signature **Relationship** **Date**

BILLING CHARGES: 1.5% Billing charge will be added to all accounts outstanding after 45 days. 1.5% Periodic rate, 18% Annual rate
Any past due account referred to our collection service is subject to a 35% handling charge.



PLEASE ANSWER IMPORTANT MEDICAL QUESTIONS ON BACK

MEDICAL HISTORY

Reserved for Patient Identification Label

1. Do you take blood thinner or daily aspirin? _____yes _____no
2. Have you ever had excessive bleeding? _____yes _____no
3. Do any family members have a bleeding disorder? _____yes _____no
4. Are you taking or have you ever taken these medications for osteoporosis or osteopenia:
   Actonel, Boniva, Fosamax, Reclast, Prolia ____yes _____no
5. Have you had chemotherapy for bone disease, breast cancer, prostate cancer, multiple myeloma, etc.? ____yes _____no
   If YES, have you taken any of the following: Zometa, Aredia, Avastin, XGeva _____yes _____no _____not sure
6. Are you, or have you been, in a drug or alcohol recovery program? _____yes _____no
7. Check yes or no on any of the following you have now or have had in the past:

Heart Trouble	______yes ______no	Jaundice	______yes ______no
Congenital Heart Lesions	______yes ______no	Fainting	______yes ______no
Heart Murmur	______yes ______no	Hepatitis	______yes ______no
High Blood Pressure	______yes ______no	Tuberculosis	______yes ______no
Heart Valve Problems	______yes ______no	Seizures	______yes ______no
Rheumatic Fever	______yes ______no	Epilepsy	______yes ______no
Psychiatric Treatment	______yes ______no	Asthma	______yes ______no
Stroke	______yes ______no	Diabetes	______yes ______no
Joint Replacement	______yes ______no	If Yes: Diet Control____________	
Transplant Surgery	______yes ______no	Tablets________________	
		Insulin Amount _________	

8. Do you have a primary care physician? _____yes _____no Doctor's name____
9. Have you been under the care of a physician during the past 2 years? _____yes _____no
   Doctor's name____ Dates______________________________
   Reason____
10. Do you have any problems with your immune system or with healing? _____yes _____no
11. Do you have any problems with recurrent infections of any kind? _____yes _____no
12. What operations have you had in the past? PLEASE list with approximate dates.
    ____
    ____
13. Please list any medications you are currently taking including prescription, over the counter, herbal or holistic and vitamins.
    ____
    ____
14. Do you have any allergies (include ALL allergies): _____yes _____no
    Please list____
15. Do you have any sensitivities to medication? ______yes _______no
    Please list____
16. Any other information about your health that we should know about? _____yes _____no
    Please explain____
17. Your approximate weight____________
18. Females: Is it possible that you are pregnant?_______________ Are you nursing?___________________
19. Do you smoke? _______yes [_______amt per day] _______no
    Have you smoked in the past? _______yes _______no
20. Do you wear contact lenses? _______yes _______no

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

________________________ ____

Date Signature of person completing Health History/Legal Guardian (if patient is a minor)

Clinical Signature ________________________Date_________ Doctor Signature_______________________ Date__________