142 River Vista Place Twin Falls, ID 83301
Phone: (208) 734-7246 Fax: (208) 734-7484

Patient Information Form

Date _____/_____/_____ Name ____
First *Middle* *Last*

Gender: Male _____ Female_____ Status: Single _____ Married _____ Child_____ Birthdate _____/_____/_____

SSN: ________ - ________ - _________

Address: ____________________________ City: ______________ State: ________ Zip: _________

Email: ______________________ Home Phone: (____) ______________ Cell Phone: (____) ______________

Employer: ____________________________________ Phone: (____) ____________________

Emergency Contact: ______________________________ Phone: (____) ____________________

Person responsible for account if other than yourself:

Name: __________________________ Birthdate: _____/_____/_____ SSN: ____________________

Billing Address: ____

Contact Phone: (____) ______________ Relationship to patient: ______________________________

Employer: ____________________________ Phone Number: (____) ______________________

If patient is a minor: Mother's Birthdate: _____/_____/_____ Father's Birthdate: _____/_____/_____

Primary Insurance:

Insurance Company: ____

Insured's name: _________________________ Relation to patient: ___________________________

Address: ____

Group Name: ____________________________ Group Number: _________________________

Member ID #: ____________________________ Phone: (____) _________________________

Employer: ______________________________ Date employed: _________________________

Secondary Insurance (if applicable):

Insurance Company: ____

Insured's name: _________________________ Relation to patient: ___________________________

Address: ____

Group Name: ____________________________ Group Number: _________________________

Member ID #: ____________________________ Phone: (____) _________________________

Employer: ______________________________ Date employed: _________________________

Dental History

Name ______________________________ Age ________ Date of last exam _____/_____/_______
Former Dentist: ______________________________ Date of last dental x-rays: _____/_____/_______
Reason for today's visit: ______________________________
How often do you floss? □ Daily □ Weekly □ Rarely How often to you brush? □ 3x a day □ 2x a day □ 1x a day
Please check any of the following conditions that apply to you:

□ Bad Breath	□ Grinding teeth	□ Sensitivity to heat
□ Bleeding gums	□ Loose teeth or broken fillings	□ Sensitivity to sweets
□ Clicking or popping jaw	□ Periodontal treatment	□ Sensitivity when biting
□ Food collection between teeth	□ Sensitivity to cold	□ Sores or growths in your mouth

Medical History

Physician ______________________________ Date of last visit ____/____/____
Please list all medications you are currently taking: ______________________________
Allergies: ______________________________
Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No
Please check any of the following conditions that apply to you:

□ AIDS	□ Congenital Heart Lesions	□ Hepatitis	□ Rheumatic Fever
□ Anemia	□ Cortisone Treatments	□ Hernia Repair	□ Scarlet Fever
□ Arthritis, Rhuematism	□ Cough, Persistant	□ High Blood Pressure	□ Shortness of Breath
□ Artificial Heart Valves	□ Cough up blood	□ HIV Positive	□ Skin Rash
□ Artificial Joints	□ Diabetes	□ Jaw Pain	□ Stroke
□ Asthma	□ Epilepsy	□ Kidney Disease	□ Swelling Feet or Ankles
□ Back Problems	□ Fainting	□ Liver Disease	□ Thyroid Problems
□ Bleeding Abnormally	□ Glaucoma	□ Mitral Valve Prolapse	□ Tobacco Habit
□ Blood Disease	□ Headaches	□ Nervous Problems	□ Tonsillitis
□ Cancer	□ Heart Murmur	□ Pacemaker	□ Tuberculosis
□ Chemical Dependency	□ Heart Problems	□ Psychiatric Care	□ Ulcer
□ Chemotherapy	Describe ______________	□ Radiation Treatment	□ Venereal Disease
□ Circulatory Problems	□ Hemophilia	□ Respiratory Disease	

Have you ever taken any of these medications?
Diet Medications: □ Dexfenfluramine □ Fen-Phen □ Pondimin □ Redux
Blood Thinners: □ Coumadin □ Warfarin
Other: □ Levoxyl □ Synthroid

Are you allergic to any of the following: □ Latex □ Penicillin/Amoxicillin □ Tetracycline □ Aspirin □ Dental Anesthetics

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

______________________________ Date _____/_____/_____
Signature of Patient, Parent, Guardian or Personal Representative

______________________________ Relation to patient: ________________
Please print name of Patient, Parent, Guardian or Personal Representative

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Financial Policy

Thank you for choosing First Choice Dental. Our primary mission is to deliver the best and most comprehensive care possible. An important part of that mission is making the cost of optimal care as easy and manageable as possible by offering payment options.

Payment options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express, or Discover card
- Monthly payment plan for up to 3 months on automatic withdrawal
- Care Credit or Citihealth financing

Please Note:

First Choice Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a full refund for treatment not completed.

First Choice dental charges $25 for returned checks.

If this account is sent to collections, we agree that in addition to any amount left owing to, we will be responsible for interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balances.

____ Date ____/____/____
Patient signature/legally authorized representative

____ Relationship ___________
Printed name if signed on behalf of the patient