Michael A. Podlusky, DDS, PA • Please fill out both sides of form completely.

PATIENT INFORMATION

Patient Name _____ Date _____
Last First M.I.

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security _____ Birth Date _____

Phone (Home)_____(Work) _____ Ext. _____ (Cell)_____

E-Mail Address _____ Are you happy with your smile? ☐ Yes ☐ No

Preferred Appointment Times: ☐ Morning ☐ Afternoon ☐ Any Time ☐ M ☐ T ☐ W ☐ R

Address _____
Street Apartment

_____
City State Zip Code

Referred by _____

HEALTH INFORMATION

Date of Last Dental Visit _____ Reason for this visit _____

Have you ever had any of the following? Please check all that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Bulimia
☐ Cancer
☐ Chemotherapy
☐ Codeine Allergy
☐ Diabetes
☐ Dizziness
☐ Dry Mouth
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Heart Valve Replacement
☐ Hepatitis
☐ Herpes Lesions
☐ High Blood Pressure
☐ HIV Positive
☐ Jaundice
☐ Joint Replacements
☐ Kidney Disease
☐ Liver Disease
☐ Nervous System Disorders
☐ Osteoporosis or Osteopenia
☐ Pacemaker
☐ Penicillin Allergy
☐ Pregnancy
(Due date: _____)
☐ Psychiatric/Emotional Disorders
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stents
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
OTHER:
☐ _____
☐ _____
List meds/vitamins/supplements:
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain _____

Name of Physician _____ Phone _____
Do you have any health problems that need further clarification?
If yes, please explain _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Spouse or Responsible Party Information

Name _____ Date _____
Last First MI

☐ Male ☐ Female ☐ Patient's Spouse ☐ Person responsible for payment

Social Security _____ Birth Date _____

Phone (Home) _____ (Work) _____ Ext. _____ (Cell) _____

Address _____
Street Apartment

_____
City State Zip Code

Employment Information

The following is for: ☐ The Patient ☐ The Person responsible for payment

Employer Name _____ Occupation _____

Address _____
Street City State Zip Code

Insurance Information

PRIMARY

Name of Insured _____ Is Insured a Patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _____ ID# _____ Group # _____

Insured's Address _____

Insured's Employer Name _____

Address _____
Street City State Zip Code

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address _____

Insurance Company Phone _____

SECONDARY

Name of Insured _____ Is Insured a Patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _____ ID# _____ Group # _____

Insured's Address _____

Insured's Employer Name _____

Address _____
Street City State Zip Code

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address _____

Insurance Company Phone _____

Dental Financial Policy

The following financial policy applies to all patients. Please read carefully and sign this agreement providing you agree with it. Let our staff know if you have any questions.

1) PAY AS YOU GO. Pay for each individual service when services are rendered. If there is an additional balance due after insurance has paid, payment from you is due upon receipt of our bill. You may pay with cash, check, Visa, Mastercard or Discover.

2) PAY IN ADVANCE. We offer a 5% discount to patients who pay for their proposed treatment with cash or check prior to treatment of $1,500.00 or more. We have found it easier and less expensive when patients pay in advance. We can then pass the savings on to you.

3) ARRANGE FINANCING WITH CARECREDIT. Through a special arrangement with CareCredit and Michael Podlusky, DDS, you may qualify to pay for your treatment with a plan that fits your budget. Ask for necessary paperwork, or apply online on our website, www.michaelpodluskydds.com.

PLEASE NOTE: A finance charge of 1.5% will apply to any account over 30 days.

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

_____ _____ _____
Signature of patient, parent or guardian Date Relationship to Patient

_____ _____ _____
Signature of guarantor of payment/responsible party Date Relationship to Patient