New Patient Medical History Form
Steven Boe, D.M.D., Stephen Page, D.M.D. & Christopher Page D.M.D.

Today's Date_____

Patient's Full Name _____ Title_____
First Name Middle Initial Last Name

Home Phone _____ Work Phone _____ Cell Phone_____
(Please circle which telephone number is best to confirm your appointments.)

E-mail _____

Naples Address _____
Street Number and Name

_____
City State Zip

Up North Address _____
Street Number and Name

_____
City State Zip

Date of Birth _____ Social Security Number_____

Sex: M or F Height _____ Weight_____ Martial Status _____

Occupation _____Employer Name _____

Emergency Contact Name _____ Phone Number_____

Relationship to Patient_____

How were you referred to our office? _____

_____

If you are completing this form for another person, what is your name and relationship to the patient?

_____
Full Name Relationship

Medical Doctor's Name _____ Phone Number_____

The name of the pharmacy you would like for us to call your prescription to:

_____

Name Location Phone Number

Check ☑ if you have had any of the following:

- ☐ AIDS/HIV Positive
- ☐ Allergies
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints *(type)*_____ *(date)*_____
- ☐ Asthma
- ☐ Blood disease/Hemophilia
- ☐ Cancer/Chemo/Radiation
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Heart murmur/Mitral valve prolapse
- ☐ Heart problems
  Describe_____
- ☐ Herpes
- ☐ Hepatitis *(type)*_____
- ☐ High blood pressure
- ☐ If you are currently taking or have taken Bisphosphonate drugs
- ☐ Jaw pain
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ Material allergies (latex, wool, metal, chemicals)
- ☐ Nursing
- ☐ Osteoporosis
- ☐ Other _____
- ☐ Pacemaker
- ☐ Pregnant (Due Date) _____
- ☐ **Pre-Medication** (Type) _____
- ☐ Psychiatric care
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Skin rash
- ☐ Stroke
- ☐ Surgical implant _____
- ☐ Thyroid disease or malfunction
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal disease

Have you ever been diagnosed with
Sleep Apnea? **Y** or **N**
If yes, do you use a CPAP? **Y** or **N**
If no, do you snore? **Y** or **N**

Medical Updates (for internal use)

Date		Date	
/ /	_____	/ /	_____
/ /	_____	/ /	_____
/ /	_____	/ /	_____
/ /	_____	/ /	_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient_____ Date_____

Please list the surgeries you have had during the past five years. (Provide the date of your surgery and the type):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list your current health issues (During the past twelve months):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list all medications & vitamins you are currently taking:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Please list all medications that you are allergic to:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

DENTAL INSURANCE COVERAGE INFORMATION

Primary Insurance Company Name _____

Primary Insurance Co. Subscriber Name _____

Subscriber's Social Security Number or I.D. # _____

Subscriber's Date of Birth _____

Subscriber's Address _____

Relationship to Patient _____

If you have more that one insurance plan, please complete below:

Secondary Insurance Co. Name _____

Secondary Insurance Co. Subscriber Name _____

Subscriber's Date of Birth _____

Subscriber's Address _____

Relationship to Patient _____

I hereby authorize the release of any dental information, including the diagnosis and the records of treatment or examinations rendered, to my insurance company or companies.

This release is solely for the purpose of facilitating the billing and reimbursement of professional services rendered and covered under my insurance policy directly to Steven Boe DMD & Stephen Page DMD. PA.

_____

Patient Signature Date

FINANCIAL POLICY

Dental treatment is an excellent investment in an individual's medical well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people have different financial obligations, we provide the following payment options.

- We accept cash, check, or credit card (Visa, MasterCard, Discover and American Express).

- Financing is provided by Care Credit. Care Credit is very similar to a credit card. It allows you to pay for your dental service over a period of time. You can choose a plan that allows you to pay your account in full within 3 or 6 months "interest free" or you can choose to finance your dental treatment over 24, 36, 48 and 60 months with interest.

- Dental insurance is a great benefit and we will submit all the necessary paper work so that your insurance carrier will reimburse you according to your dental benefits. Your insurance contract is between you and your insurance company. We ask that you pay for your dental services on that day that we provide them.

- If you are having extensive dental treatment and you have dental insurance, we will submit a Pre-determination to your insurance carrier prior to treatment. They will provide us with an Explanation of Benefits (EOB). On the day of service, you will be responsible for paying the difference between what the EOB states that the insurance company will pay and the actual treatment cost.

Remember that a Pre-determination is not a guarantee of payment. Your benefits are subject to your eligibility and plan limitations at the time of actual treatment. If for any reason your insurance company does not pay us according to the EOB, you will be responsible for the outstanding balance.

We encourage open communication and we will gladly discuss any questions or concerns you may have.

Signed _____ Date_____

BROKEN APPOINTMENT POLICY

In order to fulfill our goal of providing quality dental care to each of our patients, dedication is required from our doctors and from each member of our staff. However, this also requires a commitment by our patients to keep their scheduled appointments. Therefore, if you are unable to keep your appointment, a 24-hour notice is needed. Exceptions are made for emergencies and unexpected illnesses. Our office is open Monday through Friday and this will allow time to reschedule or cancel an appointment. When prior notification is not given, a missed appointment fee will be charged.

Remember, we have reserved time especially for you!