Cosmetic & Implant DENTISTRY
Dr. John Hopp

PATIENT INFORMATION Date ____________

Patient Name ____________ Male / Female
Street Address ____________ Mailing Address ____________
City & Zip ____________ Birthdate ____________
Home Phone ____________ Work Phone ____________
Cell Phone ____________
Marital Status ____________ Name of Spouse ____________
Social Security # (if child, give parent's) ____________

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name ____________ Relationship ____________
Address ____________
Home Phone ____________ Work Phone ____________
Employer ____________ S.S. # ____________

DENTAL INSURANCE INFORMATION

Primary Insurance Company
Employee ____________ Relationship ____________
S.S. # ____________ Birthdate ____________
Employer ____________ Policy # ____________

Secondary Insurance Company
Employee ____________ Relationship ____________
S.S. # ____________ Birthdate ____________
Employer ____________ Policy # ____________

In case of emergency, who should be notified? ____________
Name ____________ Phone ____________
Whom may we thank for referring you to our office? ____________

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

I understand that payment is my obligation regardless of insurance. I agree that payment is due and payable in full at the time services are rendered. I agree to pay a 2% finance fee per month on any balance outstanding 45 days from the date of service. I also agree to pay any and all collection and legal fees incurred in the collection of my outstanding balance.

I authorize the release of any information required to third party payors or other health practitioners. I hereby authorize Dr. John Hopp and/or his associates to perform any and all treatment for the above named patient, including the use of local anesthetic or nitrous oxide as indicated.

Signature ____________

If other than patient, indicate relationship: ____________ Date ____________

1313 W. 4th St. • Gillette, Wyoming 82716 • Phone (307) 687-0444 • Fax (307) 687-2887

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Patient Name ______________________________

Update ____________________ Update__________/__________/__________/__________/__________

Update__________/__________/__________/__________/__________/__________/__________/__________

HEALTH INFORMATION

Personal Medical Doctor ______________________________

YES	NO	
____	____	1. Have you been hospitalized within the past 2 years? For What? ________________ ______________________________
____	____	2. Are you currently being treated by a physician? For What? ____________________ ______________________________
____	____	3. Are you currently taking any medicines or drugs? What?______________________ ______________________________
____	____	4. Have you ever received counseling for excessive use of alcohol and/ or prescription drugs?
____	____	5. Are you allergic to any drugs? What? ______________________________
____	____	6. Are you allergic to latex?
____	____	7. Have you ever had a skin rash or other reaction to metal jewelry?
____	____	8. Do you bleed excessively upon injury?
____	____	9. Have you ever been involved with dental/medical legal activity?
____	____	10. Are you pregnant?
____	____	11. Are you taking birth control pills?

CIRCLE ANY OF THE FOLLOWING CONDITION YOU HAVE HAD:

A. AIDS
B. Arthritis
C. Asthma
D. Cancer
E. Diabetes
F. Epilepsy
G. Glaucoma
H. Heart Murmur
I. Heart Problems

J. Hepatitis
K. High Blood Pressure
L. Jaundice
M. Kidney Problems
N. Low Blood Pressure
O. Nervous Breakdown or Psychiatric Treatment
P. Rheumatic Fever
Q. Sexually Transmitted Diseases

R. Stroke
S. Tuberculosis
T. Other Diseases
I or T: Describe
____
____
____

Pharmacy
____

The information is correct to the best of my knowledge. I understand that this information is confidential and that it is my responsibility to inform this office of any changes in my medical or dental status.

Signature ______________________________ Date ________________

Reviewed by ______________________________

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