NOELRIDGE DENTAL

1201 42nd St NE | Cedar Rapids, IA 52402 | noelridgedental.com

(319) 393-6152 | Find us on

Welcome!

Reset Form

Date _____

Patient Information (Confidential)

First Name _____ M.I. _____ Last Name _____ Birthdate _____

Phone _____ Email _____ SSN# _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ M ☐ F

Employer _____ Work Phone _____ Occupation _____

Spouse/Parent's Name _____ Employer _____ Work Phone _____

Emergency Contact Name _____ Phone _____

Primary Dental Insurance

Name of Policy Holder _____ Relationship to Patient _____

Birthdate _____ SSN# or ID# _____ Employer _____

Work Phone _____ Insurance Company _____

Secondary Dental Insurance

Policy Holder _____

Relationship to Patient _____

Birthdate _____ SSN# or ID# _____

Employer _____ Work Phone _____

Insurance Company _____

Previous Dental Provider

Previous Dental Office _____

_____

Previous Dentist _____

City _____ State _____

Date of Last Cleaning and Exam _____

Financial Agreement

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment. Acceptable payment options include cash, check, credit/debit card or money order.

Patients with Insurance: The PATIENT is responsible for the ESTIMATED non-covered portion of services and/or any deductibles at the time of service.

Parents not accompanying their child to an appointment: PRIOR arrangements must be made for payment.

Parents accompanying their children to an appointment: parents are financially responsible for payment.

Because instruments, chairs and personnel are reserved exclusively for your appointment, there may be a fee charged for changed or broken appointments less than 24 hours in advance. Multiple missed appointments may result in the release of dental care from Noelridge Dental.

I, _____, agree to these financial terms.

Signature _____ Date _____

Over Please!

Patient Medical History

Date _____

Physician _____

	Yes	No
Are you under medical treatment now?	☐	☐
Have you been hospitalized for any surgical operations or serious illness within the last year? If yes, explain:	☐	☐

_____

_____

_____

List any medications you are currently taking:

_____

_____

_____

Allergies

Are you allergic or had any reactions to the following?

	Yes	No
Local Anesthetic (eg. novocaine)	☐	☐
Penicillin	☐	☐
Ibuprofen	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Any metals (eg. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Sulfa	☐	☐
Other _____	☐	☐

Women Only

	Yes	No
Are you, or think you might be, pregnant?	☐	☐

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you clench or grind your teeth?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐

Please indicate if you have any of the following health conditions:

	Yes	No
AIDS or HIV Infection	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Bleeding Problems	☐	☐
Blood Thinners	☐	☐
Cancer	☐	☐
Cardiac Pacemaker	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Fainting/Seizures	☐	☐
Heart Disease	☐	☐

	Yes	No
Heart Murmur	☐	☐
Hepatitis/Jaundice	☐	☐
High Blood Pressure	☐	☐
Joint Replacement or Implant	☐	☐

Describe Surgery _____

_____

_____

Date _____

Doctor _____

	Yes	No
Kidney Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Radiation Therapy	☐	☐
Sexually Transmitted Disease	☐	☐
Stroke	☐	☐
Sleep Apnea	☐	☐
Sinus Trouble	☐	☐
Tuberculosis	☐	☐

Other _____

_____