Pronghorn Family Dentistry
307-686-1605

Patient Information

First Name	Last Name	MI	Preferred Name
Address	City	State	Zip
Home Number	Cell Number	Work Number	
Date of Birth	Gender □ M □F	SSN	E-mail address

Marital Status □ Single □ Married □ Divorced □ Separated □ Widowed □ Life Partner

Employer	Occupation	Referred by
Primary Care Provider	Referring Provider	

Responsible Party □ **Same as patient**

First Name	Last Name	MI	Preferred Name
Address	City	State	Zip
Home Number	Cell Number	Work Number	
Date of Birth	Relationship to Patient	SSN	

Emergency Contact

First Name	Last Name	Phone Number

Insurance Information

Subscriber Information

First Name	Last Name	MI	Preferred Name
Address	City	State	Zip
Date of Birth	SSN	Patient Relationship to Subscriber □ Self □ Spouse □ Child □ Other _____	
Primary Insurance Carrier	Subscriber Employer		
Phone Number of Insurance Company	Group Number: ID/Policy Number:		

Do you have secondary insurance? □ Yes □ No

Financial Guidelines

Insurance: We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar. We are in network for Delta Dental Premier. No estimate is a guarantee of payment. Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to lesser reimbursement level in which case, you would be responsible for the difference.

Payments: Patient portion or patient co-pay is due at the time of services as rendered- unless prior financial arrangements have been made. We accept all major credit cards. Balances left over 90 days will incur 18% interest.

By signing I acknowledge I have read and understand Financial Guidelines: Signature:_____

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Previous Dentist Information

Dentist Name/office:	Clinic/Facility Name
Phone Number	Reason for changing:

Dental History

Oral Health: □ Excellent □ Good □ Fair □ Poor	Last Dental Visit:
□Yes □No	Are you currently having dental discomfort? If yes, Explain:
□Yes □No	Any unhappy/unpleasant dental experiences? If yes, Explain:
□Yes □No	Any injuries to mouth/teeth/head? If yes Explain:
□Yes □No	Any missing teeth other than wisdom teeth or orthodontic extractions?
□Yes □No	Have missing teeth been replaced?
□Yes □No	Orthodontic appliances now or in the past?
□Yes □No	Gums bleed when brushing or flossing?
□Yes □No	Concerned about gum disease? History of gum disease □Yes □ No
□Yes □No	Does it hurt to bite or chew?
□Yes □No	Do you grind or clench your teeth? If so, do you wear a night guard/splint? □Yes □ No
□Yes □No	Do you want to become a regular continuing care patient in our practice?
□Yes □No	Does any type of dental treatment make you nervous? If yes, explain

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office:

Any additional concerns/comments?

Child/Minor Patients: Please answer the following questions

□Yes □No	Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottles, pacifiers, etc.)
□Yes □No	Any unusual speech habits? If yes, explain
□Yes □No	Any lost teeth? If yes, list
□Yes □No	Does the patient receive assistance with brushing and flossing? If yes, how often?

Sleep Health

□Yes □No	Do you snore loudly (loud enough to be heard through closed doors or your bed-partner elbow you for snoring at night?
□Yes □No	Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving?)
□Yes □No	Has anyone observed you stop breathing or choking/gasping during your sleep?
□Yes □No	Do you have or are being treated for high blood pressure?
□Yes □No	Body mass index - more than 10% over ideal range.
□Yes □No	Older than 50?
□Yes □No	Neck size: Male is your shirt collar 17" or larger? Female, is your shirt collar 16" or larger?
□Yes □No	Gender: Male?

Primary Physician Information

Primary Physician:	Telephone number:

Pharmacy Information

Pharmacy Preferred:	Telephone number:

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Medical History

General Health □ Excellent □ Good □ Fair □ Poor

□Yes □No	Under a physician's care now?
□Yes □No	Any hospitalization in the past 5 years?
□Yes □No	Any serious illness/surgeries?
□Yes □No	Use tobacco in any form? If yes, what type:
□Yes □No	Is pre-medication required before dental visits due to heart condition or artificial joint?
□Yes □No	Taking any prescription or daily OTC medications/drugs?
□Yes □No	Do you know of any reason why routine dental procedures might pose a risk to you, our staff or other patients? If yes, describe:

Female Patients

□Yes □No	Currently nursing?	□Yes □No	Currently Pregnant	Due date:

All Patients: Do you have, or have you ever had any of the following? (check all that apply)

□ Acid Reflux	□Weight Loss Surgery	□ Hearing Problems	□ Radiation/ Chemo	□ NONE
□ ADHD	□ Cancer/Malignancy	□ Heart attack	□ Respiratory Disease	
□ AIDS/HIV	□Cerebral Palsy	□Heart Disease	□ Rheumatic Fever	
□Anemia	□Chemical Dependency	□Heart Murmur	□Sinus Problems	
□Anxiety	□Chicken Pox	□Hepatitis	□Stroke	
□Artificial Heart Valve	□Depression	□ High blood pressure	□ Thyroid Condition	
□Artificial Joints	□Diabetes	□ Kidney Disease	□Tuberculosis	
□Arthritis	□Dizziness/Fainting	□ Liver Problems	□ Ulcers	
□Asthma	□Epilepsy/Seizures	□Mitral Valve Prolapse	□ Venereal Disease	
□Autism/Asperger's	□Frequent Ear Infection	□Mononucleosis	□ Other:	
□Bleeding Disorder	□Frequent Headaches	□ Psychiatric Treatment		

All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (check all that apply)

□Aspirin	□Codeine	□Lactose intolerance	□Sulfa Drugs	□ NONE
□Anesthetic - Local	□Dairy	□Metal Sensitivity	□Penicillin/Other Antibiotics	
□Barbiturates	□Gluten	□Sleeping Pills	□ Other:	

Medication Information

All Patients: List all medications, over the counter medication, supplements

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Office Policy

Short Cancelled/Missed Appointments

Please give 24 hours notice if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

Short Cancelled/Missed Appointments will be charged $40. If you have an extended appointment of 90 minutes the fee will be $60, if the appointment is 2 hours or longer the fee will be $100. Fee must be paid within 30 days. All appointments will be suspended until fee is paid. You may also be dismissed from our practice if you have more than 3 missed appointments.

Acknowledgment of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions. But if you do agree, then you are bound to abide by such restrictions.

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Dr. Strohschein of the dental benefits otherwise payable to me.

I hereby authorize Dr. Strohschein to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental/medical professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

Signature: **Date:**

Relationship to Patient: □ Adult Patient □ Parent □ Guardian □ Other: