

Patient Information

Patient Name : _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____ Driver License: _____
Phone Home: _____ Work: _____ Ext: _____ Mobile: _____
Email: _____ Preferred contact method: Text Email Phone
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Allergies, seasonal | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Slow-healing wounds |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> STD |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Swelling of extremities |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | Due date: _____ | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis type: _____ | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Tumors on head/neck |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Wear contact lenses |
| <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Weight loss, unexplained |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> OTHER: _____ |

• List all prescription and over-the-counter medications and vitamins you are taking: _____

• List all drug and material allergies such as penicillin or iodine: _____

• 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? Yes No
If yes, please explain: _____

To the best of my knowledge, all 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: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Internet Website Insurance Location Other _____

Name of person or office referring you to our practice _____

Primary Insured Party Information

Name: _____
 Male Female Married Single Other _____
 Social Security #: _____ Birth Date: _____ Driver License# _____
 Phone Home: _____ Work: _____ Ext: _____ Mobile: _____
 Address: _____
Street Apartment #

City State Zip Code

Patient Employment Information

Employer Name: _____ Occupation: _____

Primary Insured Employment Information

Employer Name: _____ Occupation: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
 Insured's Birth Date: _____ ID #: _____ Group #: _____
 Insured's Address: _____
Street City State Zip Code
 Insured's Employer Name: _____
 Address: _____
Street City State Zip Code
 Patient's relationship to insured: Self Spouse Child Other _____
 Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
 Insured's Birth Date: _____ ID #: _____ Group #: _____
 Insured's Address: _____
Street City State Zip Code
 Insured's Employer Name: _____
 Address: _____
Street City State Zip Code
 Patient's relationship to insured: Self Spouse Child Other _____
 Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of ninety (90) days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, on my cell, or at my work to discuss matters related to this form.

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: _____