

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Address: _____
Street Apartment #

City State Zip Code

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Mobile) _____ (Work): _____ Best time to call: _____

Email: _____

Preferred Contact Method: _____ Permission to leave message on answering machine yes no

Whom may we discuss treatment or reference appointments with: _____

Health Information

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

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

DISEASES/CONITIONS:

- | | |
|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Biphosphates
(Boniva, Fosamax) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Blood Thinner
(Coumadin, Plavix) | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy |
| | Due date: _____ |

- Radiation Treatment
- Respiratory Problems
- Sinus Problems
- Stomach Problems
- Stroke/Mini stroke
- Tuberculosis

MEDICATIONS:

- _____
- _____
- _____
- _____
- _____
- _____

ALLERGIES:

- Latex Allergy
- Codeine Allergy
- Penicillin Allergy
- Sulfa Drug Allergy
- Other Allergy

- 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: _____
- Have you ever been instructed to take antibiotics prior to dental treatment (pre-medication)? Yes No
If yes, please explain: _____

To the best of my knowledge, all of 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 Another Dentist
 Dental Office Yellow Pages Newspaper Insurance Comp. Internet Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment
Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

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 six months 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 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: _____