Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Cellular (optional)_____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

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:

☐ **Heart murmur**
☐ **Mitral Valve Prolapse**
☐ **Rheumatic heart fever**
☐ **Pacemaker**
☐ **Artificial Joints**
☐ **Artificial heart valve**
☐ Angina/ Chest pain
☐ Stroke
☐ Heart surgery
☐ Diabetes
☐ High blood pressure
☐ Low blood pressure
☐ Glaucoma

☐ Anemia
☐ Blood disease
☐ Leukemia
☐ Hemophilia
☐ Blood Transfusion
☐ Lung disease/ Tuberculosis
☐ Breathing problem
☐ Asthma
☐ Emphysema
☐ Psychiatric Care/ Mental Disorders
☐ Nervous Disorders
☐ Cancer

☐ Tumors/Growths
☐ Radiation therapy
☐ Chemotherapy
☐ **Pregnancy**
Due date:_____
☐ Taking Birth Control Pills
☐ Epilepsy/ Seizure
☐ Liver Disease/ Jaundice
☐ Rheumatoid arthritis
☐ Sinus Problems
☐ TMJ/ Jaw pain
☐ Hepatitis A, B, or C

☐ Head injuries
☐ Venereal Disease
☐ Immune Deficiencies
☐ HIV Positive
☐ Use of Phen/Fen
☐ Cortisone treatment
☐ **Codeine allergy**
☐ **Penicillin allergy**
☐ **Latex allergy**
☐ **Nickel allergy**
☐ Smoking

- Please list medications you are currently taking:_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you had any serious illnesses or operations within the last six months or 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 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.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

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

Emergency Information

In case of emergency, who should be notified? _____

Person phone number_____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insured's Address: _____

Street City State Zip Code

Insured's Birth Date: _____ SS #: _____ Group #:_____

Insured's Employer Name: _____

Insurance Plan Telephone # _____

Insurance Plan Name and Address: _____

Names of other dependents covered under this plan_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insured's Address: _____

Street City State Zip Code

Insured's Birth Date: _____ SS #: _____Group #:_____

Insured's Employer Name: _____

Insurance Plan Telephone # _____

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.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party