

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone _____
 EMAIL: _____ @ _____ EMAIL: _____ @ _____
 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 visit: _____

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Allergy or Adverse Reaction to any Medication (s) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Any Environmental Allergies? _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy
Due date: _____ | OTHER:
<input type="checkbox"/> _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | |
| | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> Hyper Thyroidism | <input type="checkbox"/> Tuberculosis | |
| | <input type="checkbox"/> Jaundice | | |

• 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: _____

• Are you currently taking any medications? Yes No For what condition(s)? _____

• **List current medications:** _____

• **Is there anything else we should know about your medical history?** 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? _____

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: _____ Cell Phone _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

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 Dependant Child: student status/school
Attending? _____

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 Dependant Child: student status/school
Attending? _____

Insurance Plan Name and Address: _____

CONSENT TO SERVICES

I as a patient or guardian fully understand and agree with the following:

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

We will be happy to submit claims to your insurance company on your behalf. Please understand that insurance is not a guarantee of payment; should the insurance company deny coverage the patient will be ultimately responsible for payment. It is important that you notify our office as soon as possible if there are any changes to your dental insurance.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I also understand and agree that if my account becomes delinquent that there will be an increase of 40% over the total outstanding balance to cover all reasonable collection proceedings.

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. This office will make every effort to adhere to the original treatment plan estimate. However, there are circumstances beyond our control that may dictate the change in the treatment or estimate.

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: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

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In order for us to take better care of you, please answer these two questions:

- Is there any discomfort/pain in your mouth and or jaws/face?

- Is there anything you would like to improve about your smile?
(e.g. shape, alignment and color of your teeth?)