

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ (Mobile): _____ E-mail: _____
Preferred method of contact: _____
Address: _____
Street City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

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

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | Due date: _____ | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joint (hip,knee) | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Frequent Cold sores |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | |
| | <input type="checkbox"/> Kidney Disease | | |

- Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

- Please list any medications you are currently taking: _____

- Are you now under the care of a physician? Yes No

If yes, please explain: _____

- Name of Physician/Primary Care Doctor: _____ Phone: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

- Former Dentist Name: _____

Address: _____

Phone: _____

- Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

- Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

- Have you ever had an upsetting dental experience? Yes No

If yes, please describe: _____

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, friend Another patient, relative

Dental Office Yellow Pages Newspaper Internet _____ Work Other _____

Name of person 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 _____

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

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

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: _____

Is patient covered by additional insurance? Yes No (If yes, a secondary insurance form must be completed)

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.

Note: This office does not use amalgam (silver/mercury) fillings. Our dental treatment only utilizes tooth-colored filling material that insurance coverage may or may not reimburse to the same extent as amalgam.

This office reserves the right to charge a \$75/hour fee for appointments broken or cancelled without 24 hours advance notice.

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 hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only a minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

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: _____