Patient Information

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

Drivers License # _____ Gender: _____ Family Status: _____

Phone (Home): _____ Social Security #: _____ Birth Date: _____

Employer: _____ (Work): _____ Ext: _____

Cell Phone(optional): _____ EmailAddress: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Person Responsible For Fee: _____ Relationship: _____

Emergency Contact Name: _____ Phone: _____

How Were You Referred To Our Office: _____

Health Information

Reason for this visit: _____

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

- ☐ AIDS/HIV/ARC
- ☐ Smoking _____
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Chemotherapy
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Head Injuries
- ☐ Heart Disease/Heart Condition
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Metastatic Cancer
- ☐ Multiple Myeloma
- ☐ Hypercalcemia
- ☐ Jaw Problems/TMJ
- ☐ Paget's Disease

OTHER:
☐ _____

Medications taking:
☐ _____
_____
_____
_____
_____
_____

- Are you allergic to any of the following – Latex, Penicillin/Antibiotics, Aspirin, Dental Anesthetics? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever been told you've had a heart condition or you need to pre-medicate prior to dental visit? ☐ 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

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. We will use or disclose your health information when we are required to do so by law. We may disclose your health information to appropriate authorities if we reasonably believe that your are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, emails, postcards, or letters.

Signature:_____ Print Name:_____

Person Completing Form:_____ Date:_____

A complete copy of our Privacy Practice Statement may be obtained at our front desk.

Previous Dental History

Name of previous dentist_____Date of Last Visit_____

Reason for your last visit_____

Do you have any of your x-rays or dental records_____
If not, you may want to request your records to be forwarded to our office. It may save you from having x-rays taken here.

Chief dental complaint (if any):_____

In respect to any pervious dental treatment have you:

Ever fainted?_____Had an allergic reaction?_____Had abnormal bleeding?_____

Any other complications during or following dental treatment?_____Please explain: _____

_____

_____

Do your gums bleed on brushing or eating?_____Does food get caught between teeth?_____

Are any of your teeth sensitive to heat, cold, or pressure?_____Do you grind or clench your teeth?_____

Do any of your teeth ache?_____Any other dental complaints_____

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 #

Employment Information Of Insurance Carrier

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.

I am aware that is is my responsibility to understand my insurance requirements such as in or out of network dentists.

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 30 days, unless previously written financial arrangements are satisfied.

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