Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name
LAST FIRST MI

Date Birth Date

SSN# – –

Phone (Home)

Phone (Cell)

Phone (Work)

Email

Address
STREET

CITY STATE ZIP

Male
Female

Married
Single
Child

Do you have dental insurance? Yes No

Dental History

Other family members seen by us?

Current/Past Dentist?

What qualities do you look for in choosing a dentist?

What do you like most and least at other dental offices?

Why did you leave your last dental office?

If you could change anything about your smile, what would it be?

Reason for today's visit?

Describe your current health.

Yes No Are you currently in pain?

If YES, describe.

Yes No Do you ever have pain in your jaw joint?

Yes No Do your gums ever bleed?

Yes No Do you floss? How often? _____

Yes No Do you brush? How often? _____

Type of bristles? Hard Med Soft

Yes No Any problems with past dental work?

If YES, describe.

Medical History

Chart # OFFICE USE ONLY

Yes No Do you have a personal physician?

Dr's Name

Phone Date last visited

Yes No Are you in good health?

If NO, why?

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

If YES, why?

Yes No Are you taking any over-the-counter/prescription drugs?

If YES, list.

Do you have or ever had any of the following?

Yes No AIDS/HIV
Yes No Artificial Joints
Yes No Artificial Heart Valves
Yes No Anemia
Yes No Arthritis/Rheumatism
Yes No Asthma
Yes No Allergies
Yes No High Blood Pressure
Yes No Low Blood Pressure
Yes No Blood Transfusion
Yes No Cancer/Chemo/Radiation
Yes No Diabetes
Yes No Drug/Alcohol Abuse
Yes No Emotional/Phychiatric Probs.
Yes No Emphysema
Yes No Epilepsy/Siezures
Yes No Fainting Spells
Yes No Fever Blisters/Canker Sores
Yes No Glaucoma
Yes No Heart Problems
Yes No Congenital Heart Defect
Yes No Heart Attack/Stroke

Yes No Heart Murmur
Yes No Heart Surgery/Pacemaker
Yes No Mitral Valve Prolapse
Yes No Rheumatic Fever
Yes No Hemophilia/Ab. Bleeding
Yes No Hepatitis-Type _____
Yes No Liver Disease
Yes No Kidney Problems
Yes No Severe/Frequent Headaches
Yes No Shingles
Yes No Sinus Problems
Yes No Shortness of Breath
Yes No Smoke or Chew Tobacco
Yes No Tuberculosis
Yes No Ulcers/Colitis
Yes No Venerial Disease
Yes No Hospitalized for any reason? Please List.

Yes No Any other medical condition? Please List.

If you answered YES to any question above, please explain.

Are you allergic to any the following?

Yes No Aspirin
Yes No Barbiturates (Sleep. Pills.)
Yes No Codeine
Yes No Dental Anesthetics
Yes No Erythromycin

Yes No Latex Gloves
Yes No Penicillin
Yes No Sulfa Drugs
Yes No Any other Allergies? If YES, please list.

Women Only.

Yes No Do you take birth control pills?
Yes No Are you pregnant? If YES, due date? _____
Yes No Are you nursing?

Insurance Information

Primary

Is Insured a patient? ◯ Yes ◯ No

Insured's Name
LAST FIRST MI

Insured's Birth Date

ID#

Group #

Insured's Address
STREET

CITY STATE ZIP

Insured's Employer Name

Employer Address
STREET

CITY STATE ZIP

Patient's relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other _____

Insurance Plan Name

Insurance Plan Address
STREET

CITY STATE ZIP ( ) -
PHONE

Secondary

Is Insured a patient? ◯ Yes ◯ No

Insured's Name
LAST FIRST MI

Insured's Birth Date

ID#

Group #

Insured's Address
STREET

CITY STATE ZIP

Insured's Employer Name

Employer Address
STREET

CITY STATE ZIP

Patient's relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other _____

Insurance Plan Name

Insurance Plan Address
STREET

CITY STATE ZIP ( ) -
PHONE

Referral Information

Whom may we thank for referring you to our practice?

◯ Another Patient ◯ Yellow Pages ◯ Dental Office

◯ Other

Name of person referring?

Office Notes

Employment Information

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

Employer Name Phone

Address
STREET

CITY STATE ZIP

Occupation

Spouse or Responsible Party Information

The following is for ◯ the patient's spouse
◯ the person responsible for payment

Name
LAST FIRST MI

Date Birthdate

SSN# - - ◯ Male ◯ Female
◯ Married ◯ Single ◯ Child

Phone (Home)

Phone (Work) Best Time To Call

Address
STREET

CITY STATE ZIP

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends on 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 the 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 the 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.

In accordance with the Federal Truth-in-Lending Act, any balance older than 60 days will be subject to a billing charge of 5$ per month or finance charges of 21% APR, whichever is greater..

I understand that the fee estimate listed for this dental care can only be extended for a period of one month from the date of the patient's 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.

X
Signature of patient, parent of guardian Date

Relationship to Patient

X
Signature of guarantor of payment/responsible party Date

Relationship to Patient