Patient Information

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

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

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

Address: _____
Street Apartment # Email:

_____
City State Zip Code

Emergency Contact: _____ Ph: _____

Health Information

Date of Last Dental Visit: _____ Reason For This Visit: _____

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

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/ Heart Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Migraine/Tension Headaches
- ☐ Muscle Tenderness in Jaw/Teeth
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due Date: _____
- ☐ Radiation Treatment/ Chemo
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stents
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors Dental and/or Medical
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy/ other Narcotics
- ☐ Penicillin Allergy/ Antibiotics
- ☐ Latex Allergy
- ☐ I Have Taken Phen-Phen
- ☐ I have taken Bisphosphonates
- ☐ Use Tobacco/Alcohol
- ☐ Diagnosed w/TMJ

- 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 presently taking any medication? ☐Yes ☐No If so, please list medications: _____

_____

Pharmacy used - _____ Phone: _____

To the best of my knowledge, all of the preceeding 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 _____

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: _____

Address: _____ Email: _____

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

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: _____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT.

_____ _____

SIGNED (PATIENT OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ _____

SIGNED (PATIENT OR PARENT IF MINOR) DATE

Consent of Disclosure

I hereby give this dental office consent to use and disclose my protected health information for the purposes of treatment, payments and health care operations. You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf and will be effective the day it is received in our office.

Patient: _____ Signature: _____

Date: _____ Relations: _____

Consent of Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment and a credit report may be obtained if necessary.

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 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 patients account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

A service fee of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 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 (5) days of billing if credit shall be extended. I further agree that the responsible value of the 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 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 agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian