

Patient Information

Patient Name: _____ Date: _____

Male Female Married Single Child Other

Social Security #: _____ - _____ - _____ Birth Date: ____ - ____ - ____

Home #: () _____ - _____ Work #: () _____ - _____

Address: _____

Street

Apartment

City

State

Zip Code

Who may we thank for referring you to our practice? _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

◆ In order to provide the best possible diagnosis, we require current radiographs, we will gladly request your records from your previous dentist. Please list your previous dentist's name and phone number or city and state they are located in:

◆ Have you ever had any complications following dental treatment? If yes, please explain:

◆ Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please explain: _____

◆ Are you now under the care of a physician? If yes, please explain: _____

◆ Are you currently taking any medication (Over the Counter or Prescription)? If yes, please list: _____

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

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Now Pregnant | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Due date: _____ | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Replace | | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | | OTHER: |
| | <input type="checkbox"/> Liver Disease | | <input type="checkbox"/> _____ |
| | | | <input type="checkbox"/> _____ |

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 doctor and / or staff at the next appointment without fail.

Signature of patient, parent or guardian

Date

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 costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

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.

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 of 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 of payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute 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 and your assignee, to telephone me at home or at my work to discuss matters related to this form.

I understand that specific amount of time is allotted for my visit each time I schedule and the terms for cancellation have been explained to me. I understand if I need to cancel my appointment, I need to inform the office with 24 hours notice to avoid a cancellation fee.

Signature of patient, parent or guardian

Date

Relationship to Patient

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 #

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

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: _____