

Patient Information

Patient Name: _____ Date: _____

Last, First MI (Preferred Name)

Male Female Married Single Child Other Birth Date: _____

Social Security #: _____ Drivers License#: _____

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

Fax: _____ E-mail: _____

Address: _____

Street

Apartment#

City

State

Zip Code

Employer Name: _____ Occupation: _____

Address: _____

Street

Apartment#

City

State

Zip Code

Responsible Party or Spouse Information

Responsible Party Spouse

Name: _____

Last,

First

MI

Male Female Married Single Child Other Birth Date: _____

Social Security #: _____ Drivers License#: _____

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

Address: _____

Street

Apartment#

City

State

Zip Code

Insurance Information

Responsible Party Spouse

Name of Insured: _____ Is insured a patient? Yes No

Last,

First

MI

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Employer Name: _____

Address: _____

Street

Apartment#

City

State

Zip Code

Insurance Plan Name: _____ Phone #: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend or relative Dental Office

Yellow Pages Website School Work Other _____

Name of person or office referring you to our practice: _____

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 full at the time services are performed.

Patients who have a dental insurance plan, understand that all dental services furnished are charged directly to the patient and that the patient or responsible party is personally responsible for payment of all dental services. This office will prepare patient insurance forms and 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.

I understand that the treatment investment and the fee listed for this dental care can only be extended for a period of 90 days from the date of the patient planning appointment. If the patient doesn't have a planning appointment, this courtesy will be extended for the same 90 day period from the date of the initial exam.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the Doctors reasonable fee of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable fee 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 authorize this office to use my name (in complete or edited form), photograph(s), or other images as may be necessary of me (i.e. radiographs and digital photos), with or without my given name and city for advertising, education or any other lawful purpose and I release and forever discharge said Doctor from any claim, demands or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

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 responsible party

Health History

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

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS
<input type="checkbox"/> Allergies

<input type="checkbox"/> Anaphylaxis
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Heart Valve
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Congenital Heart Disorder
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fainting
<input type="checkbox"/> Frequent Diarrhea
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Growths
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hives or Rash
<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Pregnancy Due date: _____
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Penicillin Allergy
OTHER:
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |
|--|---|--|---|

• 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: _____

• Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

• **Are you currently taking any medications?** Yes No
 If yes, please list them: _____

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: _____

