Date: _____

Patient Information

Patient Name: _____ Email: _____
Last First MI (Preferred Name)

Single_____ Married_____ Other____ Gender: _____ Drivers License #: _____

Social Security #: _____ **Birth Date**: _____

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

Address: _____
Street City State Apartment # Zip Code

Health Information: Please List All That Apply

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

- Do you need to pre-medicate for any dental work? _____ Why? _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any type of major surgery? ☐ 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: _____

☐AIDS/ HIV
☐Alzheimer's Disease
☐Anemia
☐Arthritis/ Gout
☐Artificial Heart Valve
☐Artificial Joints
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Cancer
☐Chemotherapy
☐Cold Sores
☐Congenital Heart Lesion
☐Crohn's Disease
☐Diabetes
Last A1C? _____
☐Dizziness/Fainting
☐Drug Addiction
☐Eating Disorder
☐Epilepsy/Seizures
☐Excessive Bleeding
☐Glaucoma
☐Hay Fever
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis A
☐Hepatitis B
☐Hepatitis C
☐High Blood Pressure
☐Hypoglycemia
☐Irregular Heart Beat
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Lung Disease
☐Mental Disorder
☐Mitral Valve Prolapse
☐Nervous Disorder
☐Pacemaker
☐Pregnant Due: _____
☐Psychiatric Care
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatism
☐Sinus Problems
☐Stomach Problems
☐Stroke
☐Thyroid Disease
☐ Tobacco Use:
How much? _____
☐Tuberculosis
☐Ulcers
☐Venereal Disease

Allergies:

☐ Anesthetic
☐ Aspirin, Ibuprofen
☐ Codeine
☐ Iodine
☐Penicillins
☐ Sulfa Drugs
☐ Tylenol
☐Environmental
☐Latex
☐Foods: _____
☐ Other: _____

Medications: Please list all medications or attach list

☐ Anticonvulsants: _____
☐ Antidepressants: _____
☐ Antihistamines: _____
☐ Antibiotics: _____
☐Anticoagulants: _____
☐ Aspirin, Ibuprofen or Tylenol: _____
☐ Bronchodilators: _____
☐Cortisone(Steroids): _____
☐ Diuretics: _____
☐ High Blood Pressure: _____
☐ Insulin: _____
☐ Nitroglycerine: _____
☐ Oral Contraceptives: _____
☐ Thyroid Medications: _____
☐Other: _____

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

Referral Information

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

Spouse or Responsible Parent Information

The following is for: ☐ the patient's spouse ☐ the parent responsible for payment for child

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 person(parent) 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: _____ SS/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.

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 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 60 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 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