Patient Information

Patient Name________________________________ Date:__________
Last First MI

Address: ________________________________
Street Apartment #
____
City State Zip Code

SS#______________ DOB__________ DL#__________ State__________

Home#______________ Work#______________ Ext:______

Cell#______________ Email Address ______________

☐ Married ☐ Single ☐ Child ☐ Other ☐ Male ☐ Female

Emergency Contact(other than spouse) Name______________ Phone#(_____)__________

Address ______________ Relationship __________

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: ______________

Responsible Party Information

(If same as Patient Info leave blank)

Name: ______________ Relationship to patient______________ Male/Female

Address: ________________________________
Street Apartment #
____
City State Zip Code

SS#______________ DOB__________ DL#__________ State__________

Home#______________ Work#______________ Ext.__________ Best time to call: _______

Employment Information

Employer Name______________ Phone#______________ Occupation: __________

Address: ________________________________
Street City State Zip Code

Insurance Information

Primary

Name of Insured________________________________ Are you the insured? ☐ Yes ☐ No
Last First MI

Insurance Plan Name and Address: ______________

Insurance Phone #______________ Employer Name______________

Insured's DOB__________ ID#______________ Group#______________

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary

Name of Insured________________________________ SS#______________
Last First MI

Insurance Plan Name and Address: ______________

Insurance Phone #______________ Employer Name______________

Insured's DOB__________ ID#______________ Group#______________

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Health Information

HAVE YOU EVER HAD:
_ Hepatitis
_ Liver Disease
_ Epilepsy
_ Seizures
_ Rheumatic Fever
_ Kidney Disease
_ Diabetes
_ Tuberculosis
_ Heart Trouble
_ Damage Heart Valves
_ Artificial Heart Valves
_ Congenital Heart Lesions
_ Coronary Insufficiency
_ Coronary Occlusion
_ Arteriosclerosis
_ Stroke
_ Cardiac Pacemaker
_ Heart Murmur
_ High Blood Pressure
_ Low Blood Pressure
_ Shortness of Breath
_ Chest Pains
_ Medical Treatment by X-Ray
_ Venereal Disease
_ Surgery
_ Glaucoma
_ Prostate Trouble
_ Contact Lenses
_ Drug Reaction
_ Psychiatric Treatment
_ Burning Tongue
_ Ulcer
_ Sinus Problems
_ Asthma
_ Treatment for Tumor/Growth
_ Prosthetic Replacement
(Hip, Knee, etc.)
_ HIV Positive

An Unfavorable Reaction to a Drug Such As:
_ Aspirin
_ Barbiturates
_ Anesthetics
_ Penicillin
_ Sulfa Drugs
_ Codeine
_Other__________________________
____

HAS A member of your family
_ Had Diabetes?
Who?___________________________
At What Age?____________________
IF FEMALE ARE YOU NOW:
_ Pregnant
Due Date_____________________
_ Taking anti-pregnancy drug
_ Presently in the Menopause
_ Past Menopause
ARE YOU:
_ Presently under the care of a physician
_ Taking any medication now
List of Current Medications
____
____
____
____
____
____
____
____
____
____
____
____

Or within the past year such as:
_ Anticoagulants
_ Cortisone
_ Tranquilizers
_ Nitroglycerin
_ Penicillin
_ Aspirin Daily
_ Digitalis, heart medicine
_ Medication for High Blood Pressure
_ Allergic to Dental Anesthetic
_ Aware of recent weight change
_ Subject to frequent urination
_ Often thirsty
_ Subject to frequent headaches
_ Easily exhausted or fatigued
_ Slow in healing
_ In good health now
_ Aware of grinding or clenching your teeth day or night
_ Satisfied with the appearance of your teeth

HAVE YOU:
_ Ever been told you had gum trouble
_ Ever had trench mouth
_ Ever been treated for Periodontal Disease (Phorrhea)
_ Ever had Orthodontic Treatment
_ Had shifting of any teeth

DO YOU:
_ Ever have sore or popping joints
_ Ever have sore teeth
_ Ever notice your ankles swell
_ Have prolonged bleeding after injury or tooth extraction
_ Have a persistent cough or cough up blood
_ Get short of breath when you lie down or require extra pillows when you sleep
_ Have any blood disorder
_ SMOKE
____
_ USE DRUGS
____
_ USE ALCOHOL
____

Have habits such as:
_ Pencil chewing
_ Fingernail biting
_ Pipe smoking
_ Have unpleasant tastes in your mouth
_ Have bleeding gums
_ Have bad breath
_ Have tooth sensitivity to heat
_ Have tooth sensitivity to cold
_ Have tooth sensitivity to sweets
_ Use dental floss
_ Have any fear of dental treatment
_ Want to keep your teeth
_ Yes, no matter how much trouble
_ Yes, if it's not too much trouble
_ Any serious illness not listed
If so, explain:
____
____
____
Height:__________________________

Weight:__________________________

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 1_% 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

____ Date: ____________ Relationship to Patient: ____________________
Signature of guarantor of payment/responsible party