

Patient Information

Patient Name: _____ Date: _____
 Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
 Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
 Address: _____
 Street _____ Apartment # _____
 City _____ State _____ Zip Cod _____

Health Information

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

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems:

Y N DK	Y N DK	Y N DK	Y N DK
<input type="checkbox"/> AIDS	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Growths	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Tumors
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Disease	Due date: _____	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever	OTHER:
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> _____

Are you allergic or have you reacted adversely to any of the following?

Y N DK	Y N DK	Y N DK
<input type="checkbox"/> Dental Anesthetic	<input type="checkbox"/> Other Antibiotics	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Codeine or other Narcotics
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Barbiturates or Sedatives	

• 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: _____

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: _____

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: _____ 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

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: _____

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.

Signature of patient, parent or guardian

Date: _____

Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Date: _____

Relationship to Patient: _____