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Patient Information

Date ________________

Patient Name: ____ Date of Birth ______________
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Single ☐ Married ☐ Child ☐ Other Social Security#: ______________ *DL#:* ______________

Phone (Home): ______________ (Work): ______________ (Ext): ______ (Mobile): ______________

Email Address: ______________________ Which way do you prefer that we contact you? ______________

Address: ____
Street Apartment #
____
City State Zip Code

Employer Name ______________________________ Occupation ______________________

Health Information

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

☐ AIDS
☐ Allergies ____________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer,
type? ______________
☐ Diabetes, type? ______
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding, please explain what caused it
____
☐ Fainting
☐ Glaucoma
☐ Gum Disease

☐ Headaches
Migraine? __________
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis, type? ______
☐ High Blood Pressure
☐ Lung Disease
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Oral Cancer or lesion
☐ Pacemaker
☐ Pregnancy (presently)
Due date: __________
☐ Radiation Treatment,
When? ____________
☐ Respiratory Problems

☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
Please list any other drug allergies not mentioned here
____
____
____

Please list any PRESCRIPTION and/or OTC (Over The Counter) drugs you are currently taking, including vitamins or herbs.
____
____
____

Is there anything not listed here concerning your medical history we need to know about? ☐ 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: ______________

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 ______________

Who can we thank for referring you to our office? ______________________________

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: ____________________

Do we have your permission to contact you at your work number? ☐ Yes ☐ No

Address: ____________________ ____________________

Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First M1

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 1%% per month (1 8% 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