B _____
F _____

PATIENT INFORMATION

Patient Name:_____ Date:_____
Last, First MI (Preferred Name)

Gender:_____ Family Status:_____

Social Security #: _____ Birth Date: _____

PHONE (Home):_____ (Work):_____ ext_____
(Cell):_____ e-mail:_____

Address:_____
Street Apartment #

_____
City State Zip Code

HEALTH INFORMATION

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

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

- ☐AIDS
- ☐Allergies _____ _____
- ☐Anemia
- ☐Arthritis
- ☐Artificial Joints
- ☐Asthma
- ☐Blood Disease
- ☐Cancer
- ☐Diabetes
- ☐Dizziness
- ☐Epilepsy
- ☐Excessive Bleeding
- ☐Fainting
- ☐Glaucoma
- ☐Growths
- ☐Hay Fever
- ☐Head Injuries
- ☐Heart Disease
- ☐Heart Murmur
- ☐Hepatitis A, B, C
- ☐High Blood Pressure
- ☐H I V
- ☐Jaundice
- ☐Kidney Disease
- ☐Liver Disease
- ☐Mental Disorders
- ☐Pacemaker
- ☐**Pregnancy** Due date:_____
- ☐Radiation Treatment
- ☐Respiratory Problems
- ☐Rheumatic Fever
- ☐Rheumatism
- ☐Sinus Problems
- ☐Stomach Problems
- ☐Stroke
- ☐Tuberculosis
- ☐Tumors
- ☐Ulcers
- ☐Venereal Disease
- ☐Codeine Allergy
- ☐Penicillin Allergy

Other: _____

Have you ever:

SMOKED_____
If yes: freq._____

Chewed Tobacco_____
If yes: freq._____

- What medications are you currently taking? _____
  _____
- 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 problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you like your smile? _____ On a scale from 1 to 10, how do you rate your smile? _____

  If you could change one thing about your smile, what would that be?_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever had 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? ☐Family ☐ Friend ☐ Co-worker ☐ Mailer
☐Insurance ☐ 1-800 Dentist ☐ Our Website ☐ Yellow pages ☐Other_____

Name of referral source:_____

Emergency contact information:

_____ _____ _____

Name Relationship phone#

Family Medical History (Parents and siblings):

- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Respiratory Infection
- ☐ Bacterial Endocarditis
- ☐ Osteopenia
- ☐ Pre-term pregnancy
- ☐ Low birth weight babies
- ☐ Periodontal Infection (gum disease)

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):_____x_____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 ZipCode Phone

Insurance Information: _____

Carrier Name Group # ID# Phone #

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 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 90 days 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