Patient Information

Patient Name: _____ Preferred Name:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other Today's Date:____/____/_____

Birth Date:____/____/_____ Social Security #: _____-____-_____ (Required for insurance purposes)

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

Address: _____ E-Mail: _____
Street Apartment #

_____ Emergency Contact: _____
City State Zip Code Phone:_____

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
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Currently Pregnant** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ Tobacco Products
- ☐ Latex Allergy
- ☐ Medications
- ( ) High Cholesterol

Explain any checked items and <u>list medications</u>:

Annual Health Updates & Signature

Date:____/____/____ _____
Date: ____/____/____ _____
Date: ____/____/____ _____
Date: ____/____/____ _____
Date: ____/____/____ _____
Date: ____/____/____ _____
Date: ____/____/____ _____
Date: ____/____/____ _____
Date:____/____/____ _____
Date: ____/____/____ _____
Date:____/____/____ _____

- 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.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Friend

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

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

Financial Responsible Party Information

The following is for: ☐ the Patient's Spouse ☐ Other , If other please list relationship:_____

Name: _____

☐ Male ☐ Female ☐

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

Primary Insurance Information

Name of Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: ____/____/_____ Name of Primary Carrier: _____ Phone # ( ) _____-_____

Group # : _____ Social Security #____-___-_____ Member # if different from social: _____

Carrier's Address: _____
Street or P.O. Box # City State Zip Code

Group Plan Name:_____ Employer: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Is there a Secondary Insurance? _____ **Name of Secondary Insurance Carrier:**_____

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 or credit card 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 and file. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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. 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