

Patient Information

Mr. Mrs. Ms. Miss

Patient Name: _____ Date: _____
Last First MI

Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Driver's License #: _____ E-mail Address: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Fax: _____ Pager: _____ Other: _____

Preferred appointment times: Morning Afternoon Evening Any Time M T Th F Sa

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:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/ Human Immunodeficiency Virus (HIV)
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Asthma/ Lung Disease
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Drug/ Alcohol Addiction
<input type="checkbox"/> Epilepsy/ Convulsions
<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fainting
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Growths
<input type="checkbox"/> Gout
<input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injuries
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hepatitis/ Liver Problem
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Pregnancy
Due date: _____
<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> OTHER: _____

-

-

- |
|---|--|--|

Are you allergic to any of the following: Penicillin Aspirin Local Anesthetics Codeine Sulfa
 Other: _____

- 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: _____
- Are you presently taking any medications? Yes No
 If so, please list: _____
- 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 _____

Hygiene/ Habits

How do you feel about your smile? _____

How often do you brush? _____ Floss? _____

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use a soft toothbrush? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use a water pik? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any pain or soreness in teeth or gums? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to temperature? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any popping or clicking in your jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any trauma to your chin? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any orthodontic treatment? |

- | Yes | No | |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use fluoride tooth paste? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to sweets? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you clench or grind your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any teeth removed? |

What can we do for you today? _____

Other remarks: _____

Referral Information

Who may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper Internet Work Other _____

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

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Phone: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Mr. Mrs. Ms. Miss

Name: _____

Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Driver's License #: _____ E-mail Address: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Fax: _____ Pager: _____ Other: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

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: _____