Patient Information

Patient Name: ______________________________ Date: ____________
Last, First MI (Preferred Name)

Social Security #: ____________ Birth Date: __________ Marital Status: ________ Gender: *M* *F*

Phone (Home): ____________ (Work): ____________ Ext: ______ (Cell): ____________

Mailing Address: ______________________________
Street / P.O. BOX City State Zip Code

Email Address: ______________________________

Health Information

Do you currently have or have a history of any of the following?
Please check all that apply:

- ☐ Food Allergies: ________
- ☐ Latex Allergy
- ☐ Other Allergies: ________
- ☐ Anemia
- ☐ Arthritis Osteo/Rheumatoid
- ☐ Artificial Joints: ________
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Clotting Issues
- ☐ Cancer: Type ________
- ☐ Radiation or Chemo
- ☐ Circulatory Problems
- ☐ Diabetes Type 1 or 2
- ☐ Jaundice
- ☐ Epilepsy
- ☐ Dizziness / Fainting
- ☐ Stroke
- ☐ Glaucoma / Cataracts
- ☐ Hyper / Hypo Thyroid
- ☐ Heart Problems: Type: ________
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker or Defibrillator
- ☐ Artificial Heart Valve
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease Type: ________
- ☐ HIV AIDS
- ☐ Drug / Alcohol Dependency
- ☐ Kidney or Liver Disease
- ☐ High Cholesterol
- ☐ Anxiety or Panic Attacks
- ☐ ADHD or ADD
- ☐ Acid Reflux
- ☐ Osteoporosis / Osteopenia
- ☐ Respiratory Problems
- ☐ High / Low Blood Pressure
- ☐ Anorexia or Bulimia
- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Frequent Headaches
- ☐ Sinus Problems
- ☐ Celiac / Chron's Disease
- ☐ Tuberculosis
- ☐ Tumors / Growths
- ☐ Excessive Bleeding
- ☐ Head Injuries
- ☐ Hepatitis Type: ______
- ☐ Surgeries: ________________

- Do you have any health problems not listed above? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you under routine care of a physician? ☐ Yes ☐ No Date of last Medical Visit: ____________
- Name of Physician: ______________________________ Phone: ____________
- Are you allergic to any medications ☐ Yes ☐ No
  If yes, please list: ______________________________
- Have you ever had any complications following a medical or dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past three years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- **(Women)** Are you pregnant or do you suspect you may be pregnant ☐ Yes ☐ No Due Date: ____________
  Are you Nursing? ☐ Yes ☐ No Using any form of prescription Birth Control Method? ☐ Yes ☐ No
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, Please list Prescription/OTC/Herbal: ______________________________

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- Have you ever taken any of the following combination of drugs: Ionimin, Adipex, Fastin (aka: Phentermine), Pondimin (Fenfluramine), Redux (Dexfenfluramine) ☐ Yes ☐ No
- Do you use any of the following? Alcohol: Yes / No, Recreational Drugs: Yes / No Tobacco: Yes / No
  Type of Tobacco? ____________ How much Tobacco? ____________ Interested in Quitting: Yes / No
- Have you ever been told you needed to Pre-medicate with an antibiotic prior to your dental appointments? ☐ Yes ☐ No
  If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that if there are any changes in my/my child's health it is my responsibility to inform the dental professional at the next appointment.

Signature of patient, parent or guardian ______________________________

Additional Information

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

Spouse/Parent: ______________________ Relationship ______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Cell: ______________

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: ____

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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.

______________________________ Date: ____________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party