

**Patient Information**

Patient Name: \_\_\_\_\_ Preferred Name \_\_\_\_\_ Gender: \_\_\_\_\_ Date: \_\_\_\_\_

Last, First MI

Birth Date: \_\_\_\_\_ Family Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Email Address \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Address: \_\_\_\_\_

Street Apt # City State Zip Code

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street City, State

Zip Code Phone

**Whom may we thank for referring you to our practice?** \_\_\_\_\_

**Health Information**

**PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING:**

\_\_\_\_\_  
 \_\_\_\_\_

**Date of Last Dental Visit:** \_\_\_\_\_ **Reason for this visit:** \_\_\_\_\_

**Have you ever had any of the following? Please check YES or NO:**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> AIDS                     | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding                   | <input type="checkbox"/> <input type="checkbox"/> Hypoglycemia              | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Anemia                 |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease      | <input type="checkbox"/> <input type="checkbox"/> Excessive Thirst                     | <input type="checkbox"/> <input type="checkbox"/> Jaundice                  | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems                     |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                   | <input type="checkbox"/> <input type="checkbox"/> Fainting                             | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> <input type="checkbox"/> Stomach Problems                   |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis                | <input type="checkbox"/> <input type="checkbox"/> Fever Blisters                       | <input type="checkbox"/> <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> <input type="checkbox"/> Stroke                             |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints/Hips   | <input type="checkbox"/> <input type="checkbox"/> Frequent Cough                       | <input type="checkbox"/> <input type="checkbox"/> Lung Disease              | <input type="checkbox"/> <input type="checkbox"/> Swelling of Feet / Ankles or Hands |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> <input type="checkbox"/> Glaucoma                             | <input type="checkbox"/> <input type="checkbox"/> Mental Disorders          | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease                    |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                   | <input type="checkbox"/> <input type="checkbox"/> Growths                              | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse     | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> <input type="checkbox"/> Have you ever taken Phen-Phen/Redux? | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorders         | <input type="checkbox"/> <input type="checkbox"/> Tumors                             |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion        | <input type="checkbox"/> <input type="checkbox"/> Hay Fever                            | <input type="checkbox"/> <input type="checkbox"/> Pacemaker                 | <input type="checkbox"/> <input type="checkbox"/> Ulcers                             |
| <input type="checkbox"/> <input type="checkbox"/> Bruise Easily            | <input type="checkbox"/> <input type="checkbox"/> Head Injuries                        | <input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints        | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease                   |
| <input type="checkbox"/> <input type="checkbox"/> Cancer                   | <input type="checkbox"/> <input type="checkbox"/> Heart Disease                        | <input type="checkbox"/> <input type="checkbox"/> Pregnancy Due date: _____ | <input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice                    |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy / Radiation | <input type="checkbox"/> <input type="checkbox"/> Heart Trouble                        | <input type="checkbox"/> <input type="checkbox"/> Pre Med                   | <input type="checkbox"/> <input type="checkbox"/> Allergy: Penicillin                |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pain/Angina        | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur                         | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Care          | <input type="checkbox"/> <input type="checkbox"/> Allergy: Latex                     |
| <input type="checkbox"/> <input type="checkbox"/> Cold Sores               | <input type="checkbox"/> <input type="checkbox"/> Heart Surgery                        | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment       | <input type="checkbox"/> <input type="checkbox"/> Allergy: Sulfa Drugs               |
| <input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine       | <input type="checkbox"/> <input type="checkbox"/> Hemophilia                           | <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss        | <input type="checkbox"/> <input type="checkbox"/> Allergy: Ibuprofen                 |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A / B / C                  | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems      | <input type="checkbox"/> <input type="checkbox"/> Allergy: Tetracycline              |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness                | <input type="checkbox"/> <input type="checkbox"/> Herpes                               | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> <input type="checkbox"/> Allergy: Aspirin                   |
| <input type="checkbox"/> <input type="checkbox"/> Drug Addiction           | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure                  | <input type="checkbox"/> <input type="checkbox"/> Rheumatism                | <input type="checkbox"/> <input type="checkbox"/> Allergy: Codeine                   |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema                | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure                   | <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever             | <input type="checkbox"/> <input type="checkbox"/> Allergy: Epinephrine               |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures     | <input type="checkbox"/> <input type="checkbox"/> HIV                                  | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> <input type="checkbox"/> Allergies: _____                   |

- Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No
- Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ Yes No
- Do you have active decay or gum disease? \_\_\_\_\_ Yes No
- Do you brush and Floss on a routine basis? Discuss \_\_\_\_\_ Yes No
- Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No
- Do you like your smile? Why? \_\_\_\_\_ Yes No
- Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No
- Do you want to keep your remaining teeth? \_\_\_\_\_ Yes No
- Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_ Yes No
- Have your past experiences in a dental office always been positive? \_\_\_\_\_ Yes No
- Do you smoke or chew? Any sores or growths in you mouth? Discuss. \_\_\_\_\_ Yes No
- Name of previous dentist (optional): \_\_\_\_\_ Yes No
- Date of last full mouth x-rays (16 small films or panoramic): \_\_\_\_\_ Yes No

**Note to Women:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

- 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, or if my medicines change, I will inform the doctors at the next appointment without fail.

X \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature of patient, parent or guardian

### Responsible Party Information

Name: \_\_\_\_\_  Male  Female  Married  Single  Other \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment # City State Zip Code

In case of emergency, whom shall we call: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

### Insurance Information

#### Primary Insured Persons Information:

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ ID or SS#: \_\_\_\_\_  
Last First MI  
Address: \_\_\_\_\_  
Street City State Zip Code  
Employer Name & Address: \_\_\_\_\_ Group#: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Phone Number: \_\_\_\_\_

#### Secondary Insured Persons Information:

Name: \_\_\_\_\_ Birth Date \_\_\_\_\_ ID# \_\_\_\_\_  
Last First MI  
Address: \_\_\_\_\_  
Street City State Zip Code  
Employer Name & Address: \_\_\_\_\_ Group#: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name & Phone Number: \_\_\_\_\_

### Consent for Services

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 30 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

**IT IS OUR POLICY TO CHARGE \$80.00 PER HOUR FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS**

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.

**X** \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of Responsible Party / Parent or Guardian

**In order for us to help prepare your insurance forms and assist in making collections from insurance companies, we will need the following authorizations:** I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims.

**X** \_\_\_\_\_  
Signature of Responsible Party/Parent or Guardian