Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Driver's License #:_____ State:_____ (Office Use ID) _____

Phone (Home): _____ (Work): _____ Ext:_____ Other:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Name of person to contact in case of emergency:_____ Phone #_____

Email address (optional-will not be shared) _____

Health Information

Date of Last Dental Visit: _____ REASON FOR **TODAY'S VISIT:**_____

Do you use tobacco products? ☐ Yes ☐No Type: _____

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

☐ AIDS/HIV
☐ Artificial Joints
☐ Asthma
☐ Blood Disorders
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Heart Disease
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ High Blood Pressure
☐ Jaundice
☐ Mental Disorders
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ PsychiatricTreatment
☐ Tuberculosis
☐ Venereal Disease
☐ Aspirin Allergy
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Erythromycin Allergy
☐ Clindamycin Allergy
☐ Latex Allergy
☐ Sulfa Allergy
☐ Hepatitis

OTHER:
☐ _____
(office use below)

BP :____/_____
P :_____

- Please list any medications that you take regularly._____
- 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

- **Would you like information on how to get a whiter smile**? ☐ Yes ☐ No

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Insurance Co. list of providers

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

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

Doctors
Signature:_____Date:_____

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): _____ 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

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: _____

Do you have a secondary insurance?_____ Name of insurance company _____

_____

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 and assist (within reason) in making collections from insurance companies and will credit any such collections to the patient's account. **This service is done as a courtesy to you.** However, **this dental office cannot render services on the assumption that our charges will be paid by an insurance company.**

All quotes are considered estimates and are given to patients as a courtesy.

I fully understand that any claim filed on my behalf reaching the age of 45 days will be closed and I will be fully responsible for any balance remaining.

I understand that the fee estimate listed for this dental care can only be extended for a period of three 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

- A 24 hour notice is required for all cancellations. A fee will be charged **($40 per hour reserved)** for all late cancellations and broken appointments.

- Patient portions will be collected in full upon arrival unless prior arrangements have been made.