

**Patient Information**

**Patient Name:** \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
**Gender:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_ **Student:** \_\_\_\_\_  
**Social Security #:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Phone (Home):** \_\_\_\_\_ **(Work):** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **(Cell):** \_\_\_\_\_  
**E-Mail Address:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
Street Apartment  
City State Zip Code  
**Employer Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Responsible Party Information**

**Name:** \_\_\_\_\_  Male  Female  
**Social Security #:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Phone (Home):** \_\_\_\_\_ **(Work):** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **Cell:** \_\_\_\_\_  
**E-Mail Address:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
City State Zip Code  
**Employer Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance Information**

**Name of Insured:** \_\_\_\_\_  
Last First MI  
**Insured's Birth Date:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Insurance Group #:** \_\_\_\_\_  
**Insured's Address:** \_\_\_\_\_  
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:** \_\_\_\_\_  
**Insurance Company phone number:** \_\_\_\_\_

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Website  Other \_\_\_\_\_

# 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<br><input type="checkbox"/> Alzheimer's<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Artificial Heart Valve *<br><input type="checkbox"/> Artificial Joints *<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Blood Disease<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Excessive Bleeding<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Growths | <input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Head Injuries<br><input type="checkbox"/> Heart Disease *<br><input type="checkbox"/> Heart Murmur *<br><input type="checkbox"/> Mitral Valve Prolapse *<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> A<br><input type="checkbox"/> B / C<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Low Blood Pressure<br><input type="checkbox"/> HIV<br><input type="checkbox"/> Jaundice<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders<br><input type="checkbox"/> Pacemaker *<br><input type="checkbox"/> Are you currently pregnant?<br>Due date: _____<br><input type="checkbox"/> Radiation Treatment<br><input type="checkbox"/> Respiratory Problems<br><input type="checkbox"/> Rheumatism<br><input type="checkbox"/> Rheumatic Fever *<br><input type="checkbox"/> Seasonal Allergies<br><input type="checkbox"/> Sinus Problems<br><input type="checkbox"/> Stomach Problems<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Tumors<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Venereal Disease |
|--|--|---|
- Have you ever taken:  
 Redux  
 Fen Phen  
 Fosamax  
 Zometa 10%  
 Aredia 4%  
 Misc.  
\*Approx. How Long Have You  
Been Taking the Above  
Medication?

Have you ever had any complications following dental treatment?

If yes, please explain: \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, please explain: \_\_\_\_\_

Have you ever had? Head & Neck Radiation \_\_\_\_\_ Head or Neck Injuries \_\_\_\_\_

Are you allergic to any of these or additional medications or substances? (please circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other \_\_\_\_\_

Are you taking any blood thinners? (please circle)

Coumadin Plavix Other \_\_\_\_\_

Are you currently taking any medications? Please list: \_\_\_\_\_

Do you need to be PRE-MEDICATED prior to your appt due to MVP or Rheumatic Fever? \_\_\_\_\_

Are you now under the care of a physician for medical treatment, excluding routine exams and physicals?  Yes  No

If yes, please explain: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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 \_\_\_\_\_

### Consent for Services

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 \_\_\_\_\_