

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____
Birth Date: _____ Social Security #: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Employer: _____ Occupation: _____
Drivers License: _____ Cell Phone: _____ Email: _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

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

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fen Phen | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Tobacco User pk/day |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma/ COPD | |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Are you taking or have you ever taken Bisphosphonates |
| <input type="checkbox"/> Bleeding or Clotting Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Cancer /Tumors Type Location | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Stroke | (oral: Actonel, Boniva, Didronel, Fosamax, Skelid) or |
| <input type="checkbox"/> Diabetes Type I / Type II Gestational | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid | (IV: Aredia, Zometa) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Tuberculosis | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease | ALLERGIES: |
| | <input type="checkbox"/> Liver Disease | | Seasonal / Food / Meds |
| | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Codeine | OTHER: |
| | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Pregnancy Due date: | | |

- Please list all over the counter and prescription medicines you are currently taking:

- 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

Cancellation Policy

The Cancellation Policy for this dental practice requires at least a 24 hour notice to cancel and/or reschedule your appointment. We reserve the right to charge a \$35.00 fee for those patients who do not comply with this policy.

Patient's 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 _____

Birth Date: _____ Social Security #: _____

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

Drivers License: _____ Cell Phone: _____ Email: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Insurance Information (If different than Responsible Party)

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: _____

Secondary

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: _____

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: _____