**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

 Last First MI

  Male  Female  Married  Single  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 Street Apartment #

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

 City State Zip Code

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

**Health Information**

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

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

|  |
| --- |
|  AIDS/HIV Positive |
|  **Allergies** (list below) **Infective Endocarditis** |
|  **Congenital Heart Disease** |
|  Anemia  |
|  Arthritis |
|  **Artificial Joints** |
|  Asthma |
|  Blood Disease |
|  Cancer |
|  Diabetes |
|  Dizziness |
|  Epilepsy |
|  Excessive Bleeding |
|  Fainting |
|  Glaucoma |
|  **Artificial Heart Valve** |
|  Hay Fever |
|  Head Injuries |
|  **Heart Disease** |
|  Heart Murmur |
|  Hepatitis |
|  High Blood Pressure |
|  Jaundice |
|  Kidney Disease |
|  Liver Disease |
|  Mental Disorders |
|  Nervous Disorders |
|  Pacemaker |
|  Smoker/Tobacco Use Alcohol/Drug Abuse |
|  **Osteoporosis*** **Osteoporosis-**

 **Medication**  |
|  Radiation Treatment |
|  Respiratory Problems |
|  Rheumatic Fever |
|  Rheumatism |
|  Sinus Problems |
|  Stomach Problems |
|  Stroke |
|  Tuberculosis |
|  Tumors |
|  Ulcers |
|  **Latex Allergy** |
|  Penicillin Allergy |
|  Jaw Clicking |
|  Clench/Grind Teeth |
|  Tooth Pain Bleeding Gums Difficulty Chewing |
|  Difficulty Opening or Closing Mouth  Headaches Pain in Jaw Pain in Gums Sores or Lumps in Mouth Sensitive Teeth**Are you interested in** Whitening Straightening |
| **Women:** **Pregnant** Nursing Birth Control Pills Menopause Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

• Have you ever had any complications following dental treatment?  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 drug allergies?  Yes  No If yes list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you take any medications? (Including non prescription) If so, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

• 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

**Person Responsible for Account**

 Self (skip this section)  Other (please complete the following):

Relationship to the Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Responsible Party Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

  Male  Female  Married  Single  Child  Other

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of years\_\_\_\_\_ 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:

**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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:

Signature of patient, parent or guardian