Patient Information

Patient Name: ________________________ ________________________ _____ Date:________________
Last First MI

☐ Male ☐ Female Social Security #: __________________________ Birth Date: ________________

Cell Phone: ________________ Home Phone: ______________ Work Phone:__________________________ Ext:______________

Address: ____ ________
Street Apartment #

____ ________ __________ E-Mail Address: ____________________________________
City State Zip Code

Health Information

Date of Last Dental Visit: __________ Previous Dentist: ________________ Reason for this visit: _______________

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

☐ AIDS
☐ Allergies ________________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_______
☐ Radiation
☐ Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism

☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Orthopedic Metal Rod(s)
OTHER:
☐ ______________________

☐ Earaches
☐ Jaw pain
☐ Jaw Clicking/Popping
☐ Ringing in Ears ☐ Ear Stuffiness
☐ Morning Headaches/Facial Pain

IN CASE OF EMERGENCY CALL ____ **RELATIONSHIP**__________________

TELEPHONE NUMBER (S) ______________________________ __________________________________

- 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:_________________
- Are you currently on any medications? ☐ Yes ☐ No
  If yes, please list medications:____
- 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

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

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

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

Responsible Party Information

If different from the patient information on page 1

Name: ______________________________ Credit Card #____________________________ MasterCard/VISA

☐ Male ☐ Female Social Security #: _____________________________ Birth Date: ____________________

Cell Phone: _________________ Home Phone: __________________ E-mail: ________________ ___ ____

Address: ____ ________
Street Apartment #

____ ___________________ ___________________
City State Zip Code

Responsible Party Employment Information

The following is for: ☐ the patient's spouse ☐ 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: ____

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 my treatment by this practice, I understand that the practice depends upon reimbursement from patients for costs incurred in care and treatment and therefore my financial responsibility must be determined before treatment. I further understand that all dental services (emergency or routine), must be paid for **on the day of service**. If I have dental insurance, I still agree that all out-of-pocket expenses are due and will be paid **on the day of service**. This office will help me prepare insurance forms or assist in making collections from insurance companies and will credit any such collections to my account. However, I recognize that this dental office cannot render services on the assumption that charges will be paid by an insurance company. I also 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.

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 for a representative of this practice 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