

Patient Information

Patient Name (last, first, MI) _____ Preferred Name _____ Date _____
Gender: _____ Married: _____ Single: _____ Age: _____
Social Security # _____ Date of birth _____
Phone (home) _____ (work) _____ ext. _____ (cell) _____
Email Address _____
Address _____
Street _____ Apartment # _____ City, State, Zip Code _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name (last, first, MI) _____ Male Female
 Married Single Child Other
Social Security # _____ Date of birth _____
Phone (home) _____ (work) _____ ext. _____ Best time to call _____
Address _____
Street _____ Apartment # _____ City, State, Zip Code _____

Insurance Information

Primary Insurance

Name of insured _____ Is insured a covered patient? Yes No
Insured's birth date _____ ID # _____ Group # _____
Insured's address _____
Insured's employer name _____
Employer address _____
Relationship to patient self spouse child other _____
Insurance plan name and address _____

Secondary Insurance

Name of insured _____ Is insured a covered patient? Yes No
Insured's birth date _____ ID # _____ Group # _____
Insured's address _____
Insured's employer name _____
Employer address _____
Relationship to patient self spouse child other _____
Insurance plan name and address _____

* It is not easy for an office to become familiar with the details of every dental plan it encounters. And it is, of course, the responsibility of the patient not the dental office to know what is covered and what is excluded from her or his own dental plan. We will do our best to inform you of what we know of your dental plan but ultimately you are responsible for any and all charges not covered.

Signature _____ Date: _____

Health Information

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
 Yes No Not sure/maybe

2. When was your last medical/dental checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.
 Yes No Not sure/maybe

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
 Yes No Not sure/maybe

5. Do you have any allergies? If you answered yes, please list using the categories below:
 Yes No Not sure/maybe
 - a) medications
 - b) latex/rubber products
 - c) other e.g. hayfever, foods_____
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
 Yes No Not sure/maybe

7. Do you have or have you ever had asthma? Yes No Not sure/maybe

8. Do you have or have you ever had any heart or blood pressure problems? Yes No Not sure/maybe

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
 Yes No Not sure/maybe

10. Do you have a prosthetic or artificial joint? Yes No Not sure/maybe

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
 Yes No Not sure/maybe

12. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? Yes No Not sure/maybe

13. Have you ever had hepatitis, jaundice or liver disease? Yes No Not sure/maybe

14. Do you have a bleeding problem or bleeding disorder? Yes No Not sure/maybe

15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
 Yes No Not sure/maybe

16. Do you have or have you ever had any of the following? Please check.

<input type="checkbox"/> chest pain, angina	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> pacemaker	<input type="checkbox"/> steroid therapy
<input type="checkbox"/> seizures (epilepsy)	<input type="checkbox"/> drug/alcohol dependency	<input type="checkbox"/> heart attack	<input type="checkbox"/> lung disease
<input type="checkbox"/> diabetes	<input type="checkbox"/> kidney disease	<input type="checkbox"/> stroke	<input type="checkbox"/> prosthetic heart valve
<input type="checkbox"/> tuberculosis	<input type="checkbox"/> stomach ulcers	<input type="checkbox"/> thyroid disease	<input type="checkbox"/> cancer
<input type="checkbox"/> arthritis	<input type="checkbox"/> diet pill therapy	<input type="checkbox"/> venereal disease	<input type="checkbox"/> anemia
<input type="checkbox"/> glaucoma	<input type="checkbox"/> sinus problems	<input type="checkbox"/> head injuries	<input type="checkbox"/> nervous disorders
<input type="checkbox"/> mental disorders			

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?
 Yes No Not sure/maybe

18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
 Yes No Not sure/maybe

19. Do you smoke or chew tobacco products? Yes No Not sure/maybe

20. Are you nervous during dental treatment? Yes No Not sure/maybe

21. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
 Yes No Not sure/maybe

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.

Signature of patient, parent or guardian

Date

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 _____

Consent for Services

As of 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 1.5% 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 of collection, including a 50% collection fee, attorney fees and court costs.

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 also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or medication/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions in this form accurately and to the best of my knowledge. 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