PATIENT INFORMATION

Patient Name: ____ Birth Date: ______________
Last, First MI (Preferred Name)
Email Address: ____________________________ SSN: ___________________ *Marital Status:* _______
Phone (Home): ___________ (Cell): _________________ (Work): _________________ Ext: ________
Address: ____
Street Apartment #
____
City State Zip Code

HEALTH INFORMATION

Date of last dental visit: _________________

Since your last dental visit with OUR OFFICE, have you seen another dentist for any reason? ___________
If yes, please explain: ___________________________

Please check all that apply:

- ☐ Anemia
- ☐ Arthritis
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ OTHER Allergies: ______________
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnant? Due date: _______
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Products
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

List ALL medications 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.

X______________________________________ **Date:** ____________
Signature of patient, parent or guardian

Patient Name: ____ **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 ☐ Insurance Company ☐ Other ____________

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

INSURANCE INFORMATION

Primary

Insurance Company: ________________________ Policy Holder's Name: ________________________

Secondary

Insurance Company: ________________________ Policy Holder's Name: ________________________

ADDTL INFO: ____

RESPONSIBLE PARTY INFORMATION

IF PATIENT IS OVER 18: WRITE "SELF" NEXT TO NAME ONLY AND SKIP THE OTHER AREAS.

IF PATIENT IS UNDER 18: ALL AREAS OF THIS SECTION MUST BE COMPLETED.

Name (Please Print): ____ ☐ Male ☐ Female

Social Security #: ____________________________ Birth Date: ____________________________

Phone (Home): ________________ (Cell): ____________________(Work): ________________ Ext: ______

Address: ____

Street Apartment #

____

City State Zip Code

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.

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, by cell 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.

X____ **Date:** ______________ **Relationship to Patient:**______________________

Signature of patient, parent or guardian