Patient Information

Patient Name: _____ Date: _____

Last First MI (Preferred Name) Gender: M/F Family Status: _____

Social Security#: _____ Birth Date: _____

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

Preferred appointment time: □ Morning □ Afternoon □ Evening □ Anytime □M □T □W □Th □F

Address: _____

Street Apartment #

_____

_

City State Zip Code

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	□ Excessive Bleeding	□ Liver Disease	□ Stroke
□ Allergies _____	□ Fainting	□ Mental Disorders	□ Tuberculosis
_____	□ Glaucoma	□ Nervous Disorders	□ Tumors
□ Anemia	□ Growths	□ Pacemaker	□ Ulcers
□ Arthritis	□ Hay Fever	□ Pregnancy	□ Venereal Disease
□ Artificial Joints	□ Head Injuries	Due Date: _____	□ Codeine Allergy
□ Asthma	□ Heart Disease	□ Radiation Treatment	□ Penicillin Allergy
□ Blood Disease	□ Heart Murmur	□ Respiratory Treatment	□ Osteoporosis
□ Cancer	□ Hepatitis	□ Rheumatic Fever	OTHER:
□ Diabetes	□ High Blood Pressure	□ Rheumatism	□ _____
□ Dizziness	□ Jaundice	□ Sinus Problems	□ _____
□ Epilepsy	□ Kidney Disease	□ Stomach Problems	

- 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

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: _____

Spouse or Responsible Party Information

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

Name: _____

Gender: M/F Family Status: _____

Social Security#: _____ Birth Date: _____

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

Address: _____

Street Apartment #

_____

_

City State Zip Code

Employment Information

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

Employer Name: _____ Occupation:_____

Address: _____

Street City, State Zip Code Phone #

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:_____

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:_____

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 cost 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 precious financial arrangements, must be paid for in full at the time services are performed. Patient who carry dental insurance understand that all dental services furnished are charged directly to the patient an 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 patients 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 ½ % 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 (5) days of the billing if credit shall be extended. I further agree that the reasonable value of said services shall be 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 cost 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 in 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