Patient Information

Patient Name: _____ Date:_____
Last First (Preferred Name) MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Student _____ ☐ Other_____
School/Grade

Social Security #: _____ Birth Date:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext:_____ Cell:_____

How would you like us to remind you of your appointments: Circle all that apply: Text Email Phone (C, H, W)

Emergency Contact: (Name & Nunber) _____ # _____

Drivers License #_____Email Address:_____

Employer:_____Occupation/Posiiton:_____

Dental Insurance (Primary)_____Secondary:_____

Spouse or Responsible Party Information

Same As Above ☐ The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental 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 Insurance ☐ YES ☐ NO

Referral Information

Whom may we thank for referring you? ☐ Online/Website ☐ Another patient ☐ Another Office ☐ Phonebook

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

Health Information

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

☐ AIDS	☐ Emphysema	☐ Jaundice	☐ Respiratory Problems
☐ Anemia	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Angina	☐ Excessive Bleeding	☐ Liver Disease	☐ Rheumatism
☐ Arthritis	☐ Fainting	☐ Low Blood Pressure	☐ Seizures
☐ Venereal Disease	☐ Glaucoma	☐ Lupus	☐ Sinus Problems
☐ Asthma	☐ Hay Fever	☐ Mental Disorders	☐ Stomach Problems
☐ Blood Disease	☐ Headaches	☐ Mitral Valve Prolapse	☐ Stroke
☐ Blood Transfusion	☐ Heart Attack	☐ Nervous Disorders	☐ Thyroid Problems
☐ Cancer	☐ Heart Disease	☐ Pacemaker	☐ Tuberculosis
☐ Congen. Heart Defect	☐ Heart Murmur	☐ Pregnant Currently	☐ Ulcers
☐ Diabetes	☐ Hepatitis	Due date:_____	☐ Artificial Joints/Valves
☐ Dizziness	☐ High Blood Pressure	☐ Radiation Treatment	Date Placed_____

- Are you allergic or had negative reactions to any of the following? ☐ Local Anesthetics ☐ Penicillin ☐ Sulfa Drugs ☐ Barbiturates ☐ Sedatives ☐ Codeine ☐ Aspirin ☐ Latex ☐ Metals/Jewelry ☐ Please list any others:
- Are you currently using any kind of Tobacco? (including smokeless)? ☐ Yes ☐ No How much per day?_____
- Did you formerly use any kind of Tobacco? (Cigarettes or smokeless) ☐ Yes ☐ No How long ago? _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list:_____
  _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you currently under the care of a physician? ☐ Yes ☐ No

- Name of Physician: _____ Phone:_____

- Name of Physician: _____ Phone:_____

Dental Information

Date of Last Dental Visit: _____ Reason for this visit:_____ Previous Dentist:_____

Yes	No	
☐	☐	Do you need to take an antibiotic premedication prior to dental treatment?
☐	☐	Do you have problems with dry mouth?
☐	☐	Are you satisfied with the appearance of your teeth?
☐	☐	Are you satisfied with the function of your teeth?
☐	☐	Are your teeth sensitive to hot/cold, or sweets?
☐	☐	Have you been told that you have periodontal disease?
☐	☐	Have you ever had any complications following dental treatment?
☐	☐	Does food frequently get caught between teeth?
☐	☐	Do your gums often bleed while brushing?
☐	☐	Have you noticed your teeth getting loose?
☐	☐	Have you injured your head, neck, or jaw?
☐	☐	Is it important for you to keep your teeth?

Yes	No	Problems of the jaw – Have you noticed:
☐	☐	Clicking of the Jaw?
☐	☐	Pain (joint, ear, side of face)?
☐	☐	Difficulty opening or closing?
☐	☐	Difficulty chewing?

Yes	No	Oral habits: Do you:
☐	☐	Clench or grind your teeth?
☐	☐	Bite your lips or cheek frequently?

Yes	No	Have you had:
☐	☐	Orthodontic treatment (braces)?
☐	☐	Oral surgery?
☐	☐	Gum tissue treatment?
☐	☐	A bite guard/snore appliance?

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

I HAVE RECEIVED, REVIEWED, OR WAS OFFERED NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received &/or read a copy of this.
Please Print

_____ Date_____
Signature

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/ guardian or guarantor