Patient Information

Date: ________________

Patient Name: ____ / ______________________
Last First MI preferred name

___Male _____Female ____Married ____Single ____Child ____Other______________

Social Security #: _______________________ Birth Date: _______________________________

Phone (Home): _____________________ (Work): ____________________ (Cell): ___________________

Mailing Address: ____
Street Apartment #

____
City State Zip code

Email Address: ____

Person/Telephone number to contact in an emergency: ____

Health Information

Reason for today's visit: ____

____

What do you **not** like about your teeth or your smile?

___size
___shape
___color
___missing teeth
___mobile teeth
___alignment
___unattractive fillings
___pain
___unable to eat well
___other: ____

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

___AIDS
___Asthma
___Sinus Problems
___Glaucoma
___Mental Disorders
___Tumors
___Cancer
___Diabetes
___Dizziness
___Epilepsy
___Hepatitis Type________
___Anemia
___Blood disease
___Fainting
___Liver Disease
___Tuberculosis
___Head Injuries
___Heart Disease
___Heart Murmur
___Rheumatic Fever
___High Blood Pressure
___Arthritis
___Excessive Bleeding
___Kidney Disease
___Stroke
___Hay Fever
___Pacemaker
___Radiation Treatment
___Respiratory Treatment
___Penicillin Allergy
___Rheumatism
___Artificial joints
___Jaundice
___Stomach Problems
___Growths
___Nervous Disorders
___Ulcers
___Venereal Disease
___Codeine Allergy
___ Mitral Valve Prolapse
___Sulfa Allergy

Do you smoke or use smokeless tobacco?_____________ Interested in quitting?__________
Pregnancy? _____________ Due date? ____
Are you taking birth control pills?_______(brand):_____________________________________
ARE YOU TAKING ANY ASPIRIN OR BLOOD THINNER ON A DAILY BASIS? __________
Have you taken, or are you currently taking any bisphosphonates such as Fosamax, Boniva, Actonel, etc.? If so List:____
Medications currently taking: ____

____

____

____

ALLERGIES:____

____

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? _____ Yes _____ No
If yes, please explain: ____
Please list any surgeries you have had.____

____
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 doctor at the next appointment without fail.

____Date:______________________
Signature of patient, parent or guardian

Spouse or Responsible Party Information

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): __________________Ext.__________

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

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. Therefore 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 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 the reasonable value of when said services are rendered, or with 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 here under 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, or guardian

_______________________________ date: _________ relationship to patient: ________________
Signature of guarantor of payment/responsible party