

Patient Information

First: _____ MI: _____ Last: _____ Jr/Sr: _____ Martial Status: S M D W
Street: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
Email Address: _____ Patient Birth Date: _____ Sex: (circle) M F
Patient Social Security #: _____ Who referred you to our office? _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

Dental & Health Information

Date of Last Dental Visit: _____ Chief Complaint and/or Reason for this Visit: _____

Do you have history of any of the following? Please check those that apply:

<input type="checkbox"/> AIDS or HIV	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Radiation Treatment	Women
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Fainting	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Currently pregnant
<input type="checkbox"/> Allergies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatic Fever	If yes, # of weeks: _____
<input type="checkbox"/> Anemia	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Nursing?
<input type="checkbox"/> Angina	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Taking Birth Control?
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Sinus Problems	Note: Antibiotics may alter the effectiveness of birth control pills.
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Stomach Problems	Are you Allergic to any of the following?
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hepatitis (Type _____)	<input type="checkbox"/> Stroke	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Codeine
<input type="checkbox"/> Cancer	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Dental Anesthetics
<input type="checkbox"/> Chronic Cough w/blood	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tumors	<input type="checkbox"/> Erythromycin
<input type="checkbox"/> Dental Anxiety	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Latex
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Smoke or use Tobacco	<input type="checkbox"/> Metals
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Any type of Implant	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Any type of Transplant	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Any Artificial Joint	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Other: _____
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Psychiatric Problems		

- Is your general health good? Yes No
- Have you been told by a doctor that you should be pre-medicated for dental treatment? Yes No
- Have you ever had any complications during or following dental treatment? Yes No
If yes, please explain: _____
- Are you currently taking any medications? Please list: _____
- 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 *Name of Physician: _____
If yes, please explain: _____
- Is there any other information which we should know about your health? Yes No _____

I certify that I have read and understand the above questions and acknowledge that the questions have been answered to the best of my knowledge.

Patient's Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Spouse or Responsible Party Information, if other than Patient

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

Name: _____ - Marital Status: (circle) S M D W

Social Security #: _____ Birth Date: _____ Sex: (circle) M F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Street: _____ City: _____ St: _____ Zip: _____

Employment Information

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

Employer Name: _____ Occupation: _____

Street: _____ City: _____ St: _____ Zip: _____ Work Phone: _____

Dental Insurance Information

(fill out ONLY if there is Dental Insurance to be billed by this office)

Primary Insurance Company Name: _____

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____ Full-time Student? Yes No

Secondary Insurance Company Name: _____

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____ Full-time Student? Yes No

Consent

- I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
- A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all account exceeding 60 days.
- I understand that the fee estimate listed on the Treatment Plan for dental care can only be extended for a period of six months from date of the patient examination.
- I understand the insurance estimate is only an estimate and that the actual payment may differ depending on what my insurance actually covers.
- I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
- My consent to the disclosure of records shall be effective until I revoke it in writing.
- I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

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: _____