Patient Information

Patient Name: ______________________________________ Date: __________
Last, First MI (Preferred Name)

Gender: Male ______ Female ______ Patient Social Security # ______________________ Birthdate: __________

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

Address: ______________________________________
Street Apartment #

____
City State Zip Code

Employer: ____________________ Job Title: ____________________

Who may we thank for referring you to our office? ____________________

Emergency Contact: ____________________ Relationship: ____________________

Email Address for appt. confirmations: ____________________ Text Message Confirmation? ☐Yes ☐No

Health Information

Please check Yes (Y) or No (N) if you have or have ever had the following:

Y	N	Condition
☐	☐	AIDS/HIV
☐	☐	Allergies:
		Drug: __________
		Food: __________
		Environment: __________
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Disease
☐	☐	Cancer
☐	☐	COPD
☐	☐	Diabetes
☐	☐	Eating Disorder
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Excessive Bleeding
☐	☐	Eye Surgery
☐	☐	Fainting
☐	☐	Fibromyalgia
☐	☐	Glaucoma

Y	N	Condition
☐	☐	Growth/Tumors
☐	☐	Hard of Hearing
☐	☐	Hay Fever
☐	☐	Head Injuries
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Hepatitis: Type: A B C
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Jaundice
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Mental Disorders
☐	☐	Mitral Valve Prolapse
☐	☐	Nervous Disorders
☐	☐	Pacemaker
☐	☐	Pregnancy
		Due date: __________

Y	N	Condition
☐	☐	Radiation Treatment
☐	☐	Recreational Drugs
☐	☐	Respiratory Problems
☐	☐	Rheumatic Fever
☐	☐	Sinus Problems
☐	☐	Sleep Apnea
☐	☐	CPAP
☐	☐	Stomach Problems
☐	☐	Stroke
☐	☐	Swollen Neck Glands
☐	☐	Osteoporosis Med: Current Previous
☐	☐	Thyroid Disease
☐	☐	Tobacco Use
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease

☐ Other: ____________________
____
____

Please list below all medications you currently take or provide a copy of all medications you are taking
____
____
____
____
____
____
____
____
____
____
____

- Have you ever had any complications following dental treatment? ☐ 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.

______________________________________ Date: __________

Responsible Party Information

Responsible Party: ☐ **Patient** ☐ **Spouse** ☐ **Parent**

Name: ____

☐ Male ☐ Female

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): __________ (Work):__________ (Cell): __________ Best time/# to call: ______

Address: ____

Street Apartment #

____

City State Zip Code

Responsible Party Employment Information

Employer Name:______________________________ Occupation: ______________

Address: ____

Street City, State Zip Code Phone

Responsible Party Employment Information

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: ____

Address: ____

Street City, State Zip Code Phone

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: ____

Address: ____

Street City, State Zip Code Phone

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.

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 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand there is a $50 fee for appointment cancellations with less than 24 hours notice.

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 thirty (30) 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 or guardian

______________________________ **Date:** __________ **Relationship to Patient:** __________

Signature of guarantor of payment/responsible party