

Patient Information

Patient Name: _____ Date: _____
Last First Preferred
Male _____ Female _____ Married _____ Single _____ Child _____ Other _____
Social Security#: _____ Birth Date: _____
Phone (H): _____ Work: _____ Ext: _____ Cell: _____
E-mail: _____
Address: _____

Health Information/Medical History

Date of Last Dental Visit: _____ Reason for this visit: _____
Do you have any medical conditions that we should be aware of? _____
If yes, please explain _____
Are you currently taking any prescription medications or OTC supplements? _____
If yes, please list _____
Have you ever had any complications following dental treatment? _____
If yes, please explain _____
Have you been admitted to the hospital in the last two years? _____
If yes, please explain _____
Are you currently under the care of a physician? _____
If yes, please explain _____
Name of physician/phone: _____
Have you ever had any of the following?
Allergies (including seasonal, food or drug) _____
AIDS, HIV _____
Artificial Joints _____
Bleeding disorders/diseases (anemia, excessive bleeding) _____
Cancer, radiation or chemotherapy _____
Diabetes/Kidney disease _____
Dizziness/Fainting _____
Epilepsy _____
Glaucoma/Eye problems _____
Growths/Tumors _____
Heart disease (pacemaker, MVP, heart murmur, Rheumatic fever) _____

High Blood Pressure/High Cholesterol _____
Liver Disease (including hepatitis, jaundice) _____
Are you pregnant? _____ If yes, due date _____
Respiratory problems/TB _____
Rheumatism/Arthritis/Lymes Disease _____
Stomach problems/Ulcers _____
Stroke _____
Venereal Disease _____
Do you have any health problems that need further clarification? _____
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 changes in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date

Employment Information

The following is for ___the patient ___ the person responsible for payment

Employer Name: _____

Address: _____

Insurance Information

Primary

Name of Insured: _____ is insured a patient? Y/N _____

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

Insured's Address: _____

Insured's Employer Name/Address: _____

Patient's relationship to insured: ___ Self ___ Spouse ___ Child ___ Other

Insurance Plan Name/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.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to my account.

I understand that the office policy is to have the outstanding balance paid in full prior to the release of my records, including x-rays.

I agree to be responsible for all the fees associated with the professional services rendered to me, by the doctor.

I understand that I will be responsible for all fees associated with the collection of my unpaid balance. A service charge of 1 1/2% per month on the unpaid balance will be charged on all accounts exceeding sixty days.

I have read the above conditions of treatment and payment and agree to their terms.

Signature of patient, parent or guardian/date: _____

Relationship to patient: _____

Signature of guarantor/responsible party: _____

