

Patient Information

Patient Name: _____ Date: _____
Last First MI

Male Female Married Single Child Employer: _____

Birth Date: _____ Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment Number

City State Zip Code Email Address

Emergency Contact Emergency Phone Number

Medical History

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

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> LATEX ALLERGY |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> _____ |

- 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 during the past two years? Yes No
If yes, please explain: _____

- Are you now under the care of a physician or taking **ANY** medications? 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 doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

- Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
- Dental Office Yellow Pages - which one? _____ Newspaper School Work Internet
- Other _____ Name of person or office referring you to our practice: _____

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: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Consent for Services and Acknowledgement Form

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.

PLEASE NOTE:

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 patient's primary insurance forms and will credit any insurance 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. Our office does not participate in all provider networks and does not have contracts with all insurance companies to accept discounted fees. I understand that all fee quotes are estimates and I will be required to pay my account balance if my insurance company does not pay as estimated.**

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that all balances which result from my insurance company not paying this office within 60 days of the date of service will become wholly my responsibility 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 (6) months from the date of the patient examination and may change at any time without notice.

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 agree to pay all collection fees if my account is referred to collections.

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 agree and approve to have necessary x-rays taken on me or my dependent. I also give permission for this office to perform a dental cleaning in its recommended form and type if it should be deemed necessary and if I am notified of this need and if I agree to have it rendered at that time. I understand that I may refuse any treatment that is suggested or recommended.

I have read and agree to the above conditions of treatment. I have received a copy of this office's Notice of Privacy Practices. I understand that I may refuse to sign this Acknowledgement of Receipt of Privacy Practices and Consent Form.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____