THIS INFORMATION IS NECESSARY FOR OUR FILES AND THE MAINTENANCE OF YOUR HEALTH WHILE UNDER TREATMENT. IT WILL BE CONSIDERED CONFIDENTIAL.

Patient Information

Patient Name: ______________________________ Date: ______________
Last, First MI (Preferred Name)

Preferred title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Other______________ Gender: ☐ M ☐ F

Social Security #: ______________________ Birth Date: ______________________

Phone: Home: __________ Work: ____________ Cell: ____________ Email: ______________

Preferred method of contact: ☐Home Phone ☐Work Phone ☐Cell Phone ☐ Text Message ☐ Email

Address: ____
Street City State Zip Code

Emergency Contact Name:____________________Relationship:________________Phone :______________

Medical History

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

☐ AIDS or HIV infection
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Bone Medications
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:__________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Dry Mouth
☐ Smoking
☐ Other:________
____
____

Medications taken:
____
____
____
____

- Do you require antibiotic pre-medication before 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? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________ Phone: ______________

Dental History

- Date of last dental visit: __________ Name of Dentist:__________________Phone:__________________.
- Date of last full-mouth x-rays (16 or more films):______________Date of last Panorex: ______________
- How often do you brush your teeth?________Floss?__________Have a professional cleaning?__________
- Have you ever had complications or prolonged bleeding following dental treatment? ☐ Yes ☐ No
- Do you feel pain in any of your teeth? ☐ Yes ☐ No
- Do you clench or grind your teeth? ☐ Yes ☐ No
- Do you have tightness, pain or problems in your jaw? ☐ Yes ☐ No
- Do you experience difficulty opening, closing or chewing? (Circle all that apply) ☐ Yes ☐ No
- Do you have clicking, popping or grating noises in your jaw joint? (Circle all that apply) ☐ Yes ☐ No
- Do your gums bleed when you brush or floss? ☐ Yes ☐ No
- Have you ever been treated for periodontal disease? ☐ Yes ☐ No
- Do you wear partials or dentures? ☐ Yes ☐ No
- Are you happy with the appearance of your teeth? ☐ Yes ☐ No
- Other Pertinent dental information not listed______________________________________

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

Referral Information

Reason for today's visit:____

Current or former Dentist :_______________________Phone:___________________

Address:____
Street Suite #

____
City State Zip Code

Whom may we thank for referring you to our practice______________________

Employment Information

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

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 or Social Sec. #: ________________ Group #: _______

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

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 or Social Sec.#: ________________ Group #: _______

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

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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 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.

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 (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 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 grant my permission to you or your assignee to take photographic records of my treatment which may be presented in educational/academic settings.

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