Patient Information

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Main): _____ (Alternate): _____ (Work): _____ Best time to call: _____

Address: _____

Street Apt #

_____

City State Zip Code

Email: _____

Emergency Contact (Preferably someone not living with you) Name: _____

Relationship to Patient: _____ Number: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the parent or guardian of the patient

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Main): _____ (Alternate): _____ (Work): _____ Best time to call: _____

Address: _____

If different than patient Street Apartment #

_____

City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Insurance Information

Primary

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

Last First MI

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

Insured's Address: _____

If different than patient Street City State Zip Code

Insured's Employer Name: _____

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

Secondary

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

Last First MI

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

Insured's Address: _____

If different than patient Street City State Zip Code

Insured's Employer Name: _____

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

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Health History

Patient Name: _____ Date: _____

Date of Last Dental Visit: _____ Reason for today's visit: _____

Within the last year, have there been any changes in your general health? YES NO
If yes, what kind? _____

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name and phone number: _____
Have you been admitted to the hospital or needed emergency care in the past two years? YES NO
If yes, why? _____

WOMEN ONLY: Are you pregnant? YES NO If yes, when is the due date? _____
Are you breastfeeding? YES NO

Are you now, or have you ever taken medication for the treatment of osteoporosis (bone loss) or cancer?
YES NO

Are you now, or have you ever taken any of the following medication?
☐ACTONEL ☐ACLASTA ☐AREDIA ☐BONEFIS ☐BONIVA ☐DIDRONEL

☐PROLIA ☐RECLAST ☐SKELID ☐XGEVA ☐ZOMETA ☐OTHER

Please list current medication(s) and reason taken: _____

_____
Attach additional page if necessary.

Are you allergic to?
☐Bees ☐Codeine ☐Erythromycin ☐Latex ☐Lidocaine ☐Morphine ☐Nuts ☐ Penicillin ☐Sulfa
☐Xylocaine Other allergies? _____

Do you now, or have you ever taken an antibiotic pre-medication before dental appointments? YES NO

If yes, why? _____

Do you have any artificial joints? YES NO If yes, when was the replacement? _____

Name and phone # of surgeon: _____

Do you take a blood thinner? YES NO
If yes, which kind: ☐Aspirin ☐Coumadin ☐Effient ☐Plavix ☐Other _____

Do you now, or have you ever had any of the following:
☐AIDS/HIV ☐Anemia ☐Arthritis ☐Asthma ☐Cancer ☐Cold Sores ☐Diabetes ☐Epilepsy

☐Excessive Bleeding ☐Fainting/Dizziness ☐Glaucoma ☐Head Injuries ☐Heart Disease

☐Hepatitis (A, B, C) ☐High Blood Pressure ☐Kidney Disease ☐Liver Disease ☐Mental Disorders
Please indicate which type.
☐Nervous Disorders ☐Pacemaker ☐Radiation Treatment ☐Respiratory Problems ☐Rheumatic Fever

☐Sinus Problems ☐STD's ☐Stroke ☐Tuberculosis ☐Tumors ☐ Ulcers ☐Other

Do you use tobacco? YES NO If yes, which kind: Smoke Chew
Do you use recreational drugs? YES NO

_____ Date: _____
Signature of patient, parent, or guardian.

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 1½% 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. A $20.00 fee will be applied for checks returned for any reason. A $30.00 fee may be charged for canceling your appointment without 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. 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.

If my balance remains unpaid and my account is forwarded to a collection agency I agree to reimburse the fees of that agency, which may be based on a percentage at a maximum of 30% of the debt. All associated costs and expenses, including reasonable attorneys' fees, incurred in such collection efforts will also be at my own expense.

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. _____ (Initial)

I understand that this office operates under the federal HIPAA policies, and a copy of the policy is available upon my request. _____ (Initial)

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

For Office Use Only:

Information Update

Information updated: _____ Date: _____ By: _____

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