

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI  
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code  
 Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Nearest relative not living with you: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Health Information

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

• Previous dental provider: \_\_\_\_\_

• 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: \_\_\_\_\_

Please list any medication you are presently taking: \_\_\_\_\_

• 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: \_\_\_\_\_

**Please See Reverse Side**

### Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_ Phone # \_\_\_\_\_

### Employment Information

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

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Notice of Privacy Practices

I have received a copy of, and understand, the Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### 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 1/2% per month (18% per annum) on the unpaid balance can 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. 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 give my consent to be photographed, audio and video recorded for treatment and training purposes.

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.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of Guarantor of Payment / Responsible Party

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_