Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: Male ☐ Female ☐ Patient Social Security # _____ Birthdate: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer: _____ Job Title: _____

Who may we thank for referring you to our office? _____

Emergency Contact: _____ Relationship: _____

Email Address for appt. confirmations: _____ Text Message Confirmation? ☐Yes ☐No

Health Information

Please check Yes (Y) or No (N) if you have or have ever had the following:

Y	N		Y	N		Y	N		
☐	☐	AIDS/HIV	☐	☐	Growth/Tumors	☐	☐	Radiation Treatment	☐ Other: _____
☐	☐	Allergies:	☐	☐	Hard of Hearing	☐	☐	Recreational Drugs	
		Drug: _____	☐	☐	Hay Fever	☐	☐	Respiratory Problems	
		Food: _____	☐	☐	Head Injuries				Please list below all medications you currently take or provide a copy of all medications you are taking
		Environment: _____	☐	☐	Heart Disease	☐	☐	Rheumatic Fever	
☐	☐	Anemia	☐	☐	Heart Murmur	☐	☐	Sinus Problems	
☐	☐	Arthritis	☐	☐	Hepatitis:	☐	☐	Sleep Apnea	
☐	☐	Artificial Joints			Type: A B C	☐	☐	CPAP	
☐	☐	Asthma	☐	☐	Herpes	☐	☐	Stomach Problems	
☐	☐	Blood Disease	☐	☐	High Blood Pressure	☐	☐	Stroke	
☐	☐	Cancer				☐	☐	Swollen Neck Glands	
☐	☐	COPD	☐	☐	Jaundice	☐	☐	Osteoporosis Med: Current Previous	
☐	☐	Diabetes	☐	☐	Kidney Disease				
☐	☐	Eating Disorder	☐	☐	Liver Disease	☐	☐	Thyroid Disease	
☐	☐	Emphysema	☐	☐	Mental Disorders	☐	☐	Tobacco Use	
☐	☐	Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	
☐	☐	Excessive Bleeding	☐	☐	Nervous Disorders	☐	☐	Ulcers	
☐	☐	Eye Surgery	☐	☐	Pacemaker	☐	☐	Venereal Disease	
☐	☐	Fainting	☐	☐	Pregnancy				
☐	☐	Fibromyalgia			Due date: _____				
☐	☐	Glaucoma							

- Have you ever had any complications following dental treatment? ☐ 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: _____
- 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.

_____ Date: _____

Responsible Party Information

Responsible Party: ☐ **Patient** ☐ **Spouse** ☐ **Parent**

Name: _____

☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____ Best time/# to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Responsible Party Employment Information

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#: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City, State Zip Code Phone

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#: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City, State Zip Code Phone

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

Insurance Plan Name and 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.

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 (12% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand there is a $50 fee for appointment cancellations with less than 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, or within thirty (30) 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 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