Patient Information

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

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

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

Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

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

- ☐ AIDS or HIV infection
- ☐ Angina
- ☐ Artificial Heart Valve
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes Type I or 2
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting, Seizures
- ☐ Glaucoma
- ☐ Growths
- ☐ Heart Attack
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A,B or C
- ☐ High/Low 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
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Mitral Valve Prolapse
- ☐ Bronchitis
- ☐ Convulsions
- ☐ Congestive Heart Failure
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Severe Infection
- ☐ Heroin Usage
- ☐ Autoimmune disease
- ☐ Systemic Lupus
- ☐ Emphysema
- ☐ Thyroid problems
- ☐ Cancer/Chemo/Radiation
- ☐ Cardiovascular Disease
- ☐ Sleep disorder
- ☐ Eating Disorder
- ☐ Malnutrition
- ☐ Gastrointestinal Disease
- ☐ Reflux/Persistent
- ☐ Heartburn
- ☐ Neurological Disorders
- ☐ Night sweats
- ☐ Osteoporosis
- ☐ Birth control pills
- ☐ Persistent Swollen Neck Glands
- ☐ Migraines/Severe Headaches
- ☐ Severe or Rapid Weight Loss
- ☐ Sexually Transmitted Disease
- ☐ Excessive Urination
- ☐ Hormonal Replacement
- ☐ Joint Replacements
  Where:_____
  Date: _____
  Any complications ☐ Yes ☐ No
- ☐ Smokings, snuff, chew, bidis

Allergic to:

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Ataractic Drugs
- ☐ Dental Local Anesthetics
- ☐ Sulfa
- ☐ Latex
- ☐ Penicillin
- ☐ Codeine
- ☐ Iodine
- ☐ Metals
- ☐ Animals
- ☐ Food Allergies
- ☐ Other:_____

• Height _____ •Weight _____ •Blood Pressure _____

Dental History (Only New patients please complete this area)

- When was your last dental appointment? _____
- Why are you here today? _____
- Did you have x-rays taken at other dental office? ☐ Yes ☐ No
- When did you last have your teeth cleaned? _____
- Have you had swollen areas of the gums? ☐ Yes ☐ No
- Have you ever had periodontal gum treatment? ☐ Yes ☐ No
- Have you ever had necrotizing ulcerative gingivitis? ☐ Yes ☐ No
- Are your teeth sensitive to sweets, or Hot and cold? ☐ Yes ☐ No
- Have you ever worn braces? ☐ Yes ☐ No
- Do you have any teeth missing?_____ Reasons: _____
- Have you ever worn a prosthetic appliance? _____ If not why not? _____
- Are you aware of clenching, gritting or grinding your teeth in the daytime or nighttime? ☐ Yes ☐ No
- Are you aware of any oral habits (mouth breathing, pencil biting etc)? ☐ Yes ☐ No
- Would you be very disturbed if you had to lose your teeth? ☐ Yes ☐ No
- Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
- Do your gums bleed when you brush or floss? ☐ Yes ☐ No
- Is your mouth dry? ☐ Yes ☐ No
- Is your home water supply fluoridated? ☐ Yes ☐ No
- Do you drink bottled or filtered water? ☐ Yes ☐ No
- Do you have earaches or neck pain? ☐ Yes ☐ No
- Do you have any clicking, popping or discomfort in your jaw? ☐ Yes ☐ No
- Do you brux or grind your teeth? ☐ Yes ☐ No
- Do you have sores or ulcers in your mouth? ☐ Yes ☐ No
- Have you ever had a serious injury to your head or mouth? ☐ Yes ☐ No

Medical Questions

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
  - Has your previous Dentist or physician recommended that you take antibiotics prior to your dental treatment? ☑ Yes ☑ No
- 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: _____
- Do you have any health problems, diseases or conditions 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.

_____ Date: _____
Signature of patient, parent or guardian

LIST OF MEDICATIONS: (Name of drug, Reason for drug, Dosage and how often taken)

Name:	Reason:	Dosage/ How often

Emergency Contact Name with HIPPA permission:_____ **Phone:**_____

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

☐ Dental Office ☐ Website ☐ Newspaper ☐ School ☐ Work ☐ Other _____

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

Spouse or 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

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 #: _____ 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 #: _____ 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: _____

_____

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.

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 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