

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____ **Referred by:** _____
 Social Security #: _____ Birth Date: _____ Drivers License # _____
 Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____ (Pager): _____
 Email address _____
 Address: _____
 Emergency Contact: _____

Health Information

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

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS
<input type="checkbox"/> Latex Allergy
<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Drug Allergies:

<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Stroke | <input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fainting
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Pregnant
Due Date: _____
<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Weight Gain/Loss
<u>Dental Questions:</u>
<input type="checkbox"/> Do you clench or grind your teeth?
<input type="checkbox"/> Have you had any past Periodontal treatment?
<input type="checkbox"/> Have you ever had a difficult time getting numb? |
|---|---|--|

Reason For First Visit:

- Initial Patient Exam
 Tooth Ache
 Emergency
List Med's you are currently taking:

Date of Last Dental Visit _____

- Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____
- Have you been told you need antibiotic coverage before dental procedures? 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: _____
- If you could change the appearance of your teeth, what would you change? _____
- Have you had any major surgeries?
 If yes, Please list: _____

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.

Responsible Party Information

Name: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____
Address: _____
Street Apartment #
City State Zip Code

Insurance Information

Primary
Name of Insured: _____
Last First MI
Insured's Birth Date: _____ ID #: _____ Employer _____ 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: _____
Last First MI
Insured's Birth Date: _____ ID #: _____ Employer _____ 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 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. If your insurance company has not paid within 90 days, full payment is required from the guarantor immediately. Our office will attempt to estimate your portion due; however, this is only an estimate. You are responsible for any charges your insurance company does not pay. Account balances over 90 days will be referred to Associated Receivable Consultants for collection.

We reserve the right to charge a \$50.00 broken appointment fee, if you fail to notify the office in adequate time for the appointment to be filled.

A \$5.00 dollar billing fee will be charged to your account if we are required to send more than one statement to collect a fee.

X _____ Initial

I understand a fee estimate listed for 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, I agree to pay 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.

have read the above conditions of treatment and payment and agree to their content.

I HAVE READ THE HIPAA NOTICE OF PRIVACY PRACTICES AND AGREE TO THE POLICY. X _____

INITIAL

To the best of my knowledge all of the preceding answers and information are true and correct. If I ever have any change in my health, insurance or financial information, I will inform the office without fail.

X

Date: _____ Relationship to Patient: _____

Signature of patient, parent, guardian or guarantor of payment/responsible party