

Patient Name: \_\_\_\_\_

### 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"/> Glaucoma            | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Allergies                        | <input type="checkbox"/> Growths             | <input type="checkbox"/> Respiratory Problems |
| _____   | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Allergies to medications:        | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Stomach Problems     |
| _____   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Allergy to Sulfur or Sulfa Drugs | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Artificial Joints                | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tumors               |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Blood Disease                    | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Blood Transfusion                | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Latex Allergy        |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Lung Problems       | <input type="checkbox"/> OTHER:               |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Mental Disorders    | _____   |
| <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Nervous Disorders   | _____   |
| <input type="checkbox"/> Epilepsy                         | <input type="checkbox"/> Pacemaker           |   |
| <input type="checkbox"/> Excessive Bleeding               | <input type="checkbox"/> <b>Pregnancy</b>    |   |
| <input type="checkbox"/> Fainting                         | Due date: _____                              |   |

Do you use tobacco products? \_\_\_\_\_

Please list any medications you are currently taking.

Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

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 that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

If there was an inexpensive way to whiten your teeth, would you be interested?  Yes  No

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.

### 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.

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

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: \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name) Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code  
Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient  Mail-out  
 Dental Office  Yellow Pages  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

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_