Patient Information - Please Print										
Patient Name:			Date:							
First Gender: M / F Marital Sta	tus: M / S	Last Birth Date: Mo D	_// ay Year	(Preferred Name Age:	e)					
Phone (Home):	(Work): _		,	(	(Evening):					
Name of Emergency Contact:         Phone:         Email										
Name of Pharmacy: Phone:										
Health Information										
Date of Last Dental VisitDo you have a regular dentist? Name Location										
Why are you here today	<i>?</i>									
Have you ever had any of  □ AIDS □ Anticoagulant Therapy □ Aspirin Therapy □ Anemia □ Arthritis	<ul><li>□ Heart Dise</li><li>□ Bacterial E</li></ul>	ease Endocarditis e Heart Failure stinal	☐ Rheumatis ☐ Sinus Prol ☐ Stents ☐ Stomach I ☐ Stroke	sm blems	☐ Do you use tobacco? ☐ ☐ Seafood Allergy ☐ Iodine Allergy ☐ Birth control? ☐ Seizures					
□ Artificial Heart Valves □ Artificial Joints □ Asthma □ Blood Disease	☐ Hepatitis☐ High Blood☐ Jaundice☐ Kidney Dis	Pressure ease	□ Tuberculo □ Tumors □ Ulcers □ Venereal I	Disease	☐ Congenital Heart Disease ☐ Infective Endocarditis ☐ Heart Murmur					
□ Cancer □ Diabetes □ Dizziness □ Epilepsy □ Excessive Bleeding	☐ Liver Disea ☐ Mental Disea ☐ Nervous Di ☐ Pacemakea ☐ Pregnant?	orders isorders r	□ Drug Alle □ Codeine A □ Penicillin □ Latex Alle □ Osteopor	Allergy Allergy						
☐ Fainting ☐ Glaucoma ☐ Growths ☐ Head Injuries	☐ Chronic Co ☐ Radiation ☐ ☐ Respiratory ☐ Rheumatic	onstipation Freatment y Problems	☐ Keflex Alle	ergy	□ Check here if answer is no to ALL the above					
<ul> <li>List Current Medications: <ul> <li>Have you eaten today?</li> <li>Do you use mouthwash?</li> </ul> </li> <li>Have you ever had any complications following dental treatment? □ Yes □ No <ul> <li>If yes, please explain:</li> <li>Have you been on antibiotics in the last 90 days? □ Yes □ No Which one?</li> </ul> </li> <li>Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No <ul> <li>If yes, please explain:</li> <li>Have you ever had an infection in your heart?</li> <li>Were you born with a heart defect? If so, what was done for it?</li> <li>Who is your cardiologist?</li> <li>Phone:</li> </ul> </li> </ul>										
Have you had joint replacement surgery done?										
◆ Are you now under the care of a physician? □ Yes □ No										
• Name of Physician: Phone:										
Do you have any health prob	lems that need	d further clarifica	tion? □ 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.										
Signature of patient, parent or guardian  Date:										
Whom may we thank for referring you to our practice? □Another patient, friend □another patient, relative										
□ Dental Office □ Yellow Book □ SBC Yellow Pages □ Newspaper □ School □ Work □ Other										

	Patient In	formatio	n - Please	Print		
Patient Name:		Date: Date:				
First Gender: M / F Marital Status:	MI I	Last /	/	(Preferred Name) _ Age:		
Gerider. W/ / Waritar Status.	W/ O DITTI Date	Mo Day		_ Age		
Phone (Home):	(Work):	((	Cell):		(Other):	
Address:		_				
Number	Street		City	State	Zip	
	Respons	sible Part	ty Informa	ation		
Name						
□ Male □ Female	С	☐ Married	□ Single □	☐ Child ☐ Other		
Social Security #:		Birth	Date:			
Phone (Home):	(Work):		Ext:	_ Best time to ca	all:	
Address:				Δ	partment #	
Silvet				·		
METHOD OF PAYMENT: ☐ CASH ☐	LOCAL CHECK C	VISA/MC	State		Zip Code	
The following is for: ☐ the patient	<b>Empl</b> o □ the person responsib		nformatio	on		
Employer Name:						
Address						
Street			City,	State Zip Code	Phone	
	lne	ıranca İnf	formation			
Primary						
Name of Insured:	First		MI	_ Is insured a pat	ient? □ Yes	□ No
Insured's Birth Date:						
Insured's Address:			City	State	Zip Code	
Insured's Employer Name:			Oity	State	Zip Code	
Address:						
Patient's relationship to insure	d: □ Self □ Spou	se 🗆 Child	City Other	State	Zip Code	
	·					
Secondary Name of Insured:				_ Is insured a pat	ient? □ Yes	□ No
Last	First		MI	•		
	Co	onsent for	Services			
As a condition of your treatment by this office, financial a				reimbursement from the pation	ents for the costs incurre	ed in their care and financia
responsibility on the part of each patient must be determ  All emergency dental services, or any dental services pe		al arrangoments in	auet ha paid for in a	each at the time conject are	performed	
Patients who carry dental insurance understand that all of	·	•	•		•	dental services. This office
will help prepare the patients insurance forms or assist in services on the assumption that our charges will be paid		ance companies an	nd will credit any su	ch collections to the patient's	account. However, this	s dental office cannot rende
A service charge of 11/2% per month (18% per annum) or	·	•		•	•	
I understand that the fee estimate listed for this dental ca In consideration for the professional services rendered to	,			•	,	,
services are rendered, or within five (5) days of billing if c time for payment thereof. I further agree that a waiver of reasonable attorney fees if suit be instituted hereunder.	credit shall be extended. I further	r agree that the rea	sonable value of sa	aid services shall be as billed	I unless objected to, by	me, in writing, within the
I grant my permission to you or your assignee, to telepho	one me at home or at my work to	discuss matters re	elated to this form.			
I have read the above conditions of treatment	t and payment and agree	to their conten	t.			
Signature of patient, parent or guardian	Da	ate:	Relation	ship to Patient:		
	_					
X	D	ate:	Relatio	nship to Patient:		