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Chart #:__________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Date:______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________________________ Birth Date:________________________________

Phone (Home): _______________ (Work): _____________________ (Cell):_____________________

Address: ____
Street Apartment #

____
City State Zip Code

Is the patient covered by dental insurance? ☐ Yes ☐ No

Employment Information

Employer Name: _________________________________ Occupation: __________________________

Address: ____
Street City State Zip Code

Health Information

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

☐ AIDS
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High 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
☐ Tobacco User
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ milk allergy
☐ ________________
☐ ________________

- Are you in good health? ☐ Yes ☐ No
- Are you taking any medications? ☐ Yes ☐ No
  If yes, please list:____
- 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
  Name of Physician: ____ Phone: ______________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____

>>>>>>>>>>>PLEASE TURN OVER >>>>>>>>>>>

Dental History

Approx. Date of last Dental Visit______________ What was done then? ____

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

If yes, please explain:____

Are you happy with your smile? ☐ Yes ☐ No

Do you have any dental problems or concerns you would like addressed? ☐ Yes ☐ No

If yes, please explain:____

Would you be interested in having a staff member talk to you about whitening options? ☐ Yes ☐ No

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

Employer Name & Address ____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐ Online Insurance Site

☐ Other Dental Office ☐ Yellow Pages or Local Book ☐ ☐ Co-worker ☐ Other – please describe below

(Please circle one)

Name of person or referral source referring you to our practice:____

Consent for Services-PLEASE read carefully

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patient 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. In other words, if your dental insurance company denies your claim, you must pay your balance in full at that time.

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 any fee estimates 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, 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.

To the best of my knowledge, all the preceding answers and information provided are true and correct.

***********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