BRYAN BONNET DDS
FAMILY & COSMETIC DENTISTRY

☐ New Patient
☐ Update

Patient Information

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

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____ Email:_____

Social Security #: _____ Birth Date: _____

Home Phone: _____ Work: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

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

- ☐ AIDS
- ☐ Autism
- ☐ Allergies / Seasonal
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
  Location:_____
  Year:_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinner
  Rx: _____
- ☐ Cancer
  Type: _____
  In Treatment: Y or N
- ☐ Diabetes
  Insulin: Y or N
  Rx: _____
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Attack
  Year: _____
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
  Rx: _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
  Rx: _____
- ☐ Pacemaker
- ☐ Pregnant
  Due date:_____
- ☐ Radiation Treatment
  In Treatment: Y or N
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin/ Amoxicillin Allergy
- ☐ Latex Allergy
- ☐ Pre-Med
  Reason: _____
- ☐ Other
  _____

(Office Use Only) Dr. Signature: _____

- 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 for ongoing treatment? ☐ 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:_____

Whom may we thank for referring you to our practice? _____

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

Responsible Party Information

The following is for ***the person responsible for payment***:

Name:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____ Relation to Pt: _____

Social Security #: _____ Birth Date: _____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Insurance Information

The following is for the ***person who carries the dental insurance:***

Name of Insured: _____ Insured's Birth Date: _____
Last First MI

Is insured a patient? ☐ Yes ☐ No

Insurance Employer Name: _____

Insured's Company Name: _____

Group #: _____ ID #:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

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 or credit card 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.

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.

Signature of Patient: _____ Date: _____ Relationship to Patient: _____
(Parent or Guardian if minor)

Authorization

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient: _____ Date: _____ Relationship to Patient: _____
(Parent or Guardian if minor)

Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient: _____ Date: _____ Relationship to Patient: _____
(Parent or Guardian if minor)