James W. Formaker, DDS

General and Cosmetic Dentistry

PATIENT INFORMATION

(*This information is necessary for our files and will be considered* ***CONFIDENTIAL***.)

Patient Name: ______________________________ Date: ______________________
LAST FIRST MIDDLE

Address: ______________________________

City: ______________________ State: __________ Zip: ______________

Employer: ______________________ Occupation: ______________

Address: ______________________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Email: ______________________________

Social Security Number: __________ Date of Birth: ________ Age: _____ Gender: ______ Marital Status: ____________

Whom may we thank for referring you? ______________________________

Primary Dental Insurance: ______________________ Group No.: ______________

Insured's Name: ______________ Identification Number: ____________ Date of Birth: ______________

Secondary Dental Insurance: ______________________ Group No.: ______________

Insured's Name: ______________ Identification Number: ____________ Date of Birth: ______________

MEDICAL HISTORY

Physician's Name: ______________________ Phone Number: ______________

Current Medications: ______________________________

Allergies (Check all that apply):

___ Aspirin ___ Codeine ___ Anesthetics ___ Erythromycin ___ Jewelry ___ Latex ___ Metals ___ Penicillin ___ Tetracycline

Do you smoke? ________ If yes, how many packs per day? _______ Height _________ Weight _____________ Blood Pressure ______________

Medical Alert: ______________________________

Have you ever had (Check any of the following that apply):

___ Abnormal Bleeding ___ Alcohol Abuse ___ Allergies ___ Anemia ___ Angina Pectoris ___ Arthritis ___ Artificial Bones/Joints

___ Artificial Prosthesis ___ Asthma ___ Blood Transfusion ___ Cancer/Chemo ___ Colitis ___ Congenital Heart ___ Cosmetic Surgery

___ Diabetes ___ Difficulty Breathing ___ Drug Abuse ___Emphysema ___ Epilepsy ___ Fainting Spells ___ Fever Blisters

___ Frequent Headaches ___ Glaucoma ___ Hay Fever ___ Heart Attack ___Heart Surgery ___ Hemophilia ___ Hepatitis A or B

___ Hepatitis C ___ High Blood Pres. ___ HIV/AIDS ___ Kidney Problems ___ Liver Disease ___ Low Blood Pres. ___ Mitral Valve Prolapse

___ Pace Maker ___ Pneumocyst ___ Psych. Treatment ___ Radiation Therapy ___ Rheumatic Fever ___ Seizures ___ Shingles

___ Sickle Cell Disease ___ Sinus Problems ___ Stroke ___ Thyroid Problems ___ Tuberculosis ___ Ulcers ___ Venereal Disease

___ Yellow Jaundice ___ Osteoporosis ___ Cold Sores ___ Chicken Pox ___ Bruise Easily ___ Heart Murmur ___ Pain in Jaw Joints

___ Respiratory Disease ___TMJ

Other medical conditions we should know about: ______________________________

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DENTAL HISTORY

Have you ever had any unfavorable reaction from a local anesthetic? ________________________________

Have you had any serious trouble associated with any previous dental treatment? ________________________________

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How long since your last full mouth X-Rays? ________________________________

How long since your last dental treatment? ________________________________

Does dental treatment make you nervous? ________________________________

Are you happy with your smile? ________________________________

Have you ever been pre-medicated for dental treatment? ________________________________

Who was your last dentist? ________________________________

Why are you changing dentists? ________________________________

TERMS & CONDITIONS

As a condition of treatment by Dr. Formaker, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms and will credit any collections from insurance to my account, however, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to Dr. Formaker benefits accruing to me under the policy. A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by Dr. Formaker and/or his staff, I agree to pay the reasonable value of said services 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, 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 agree to their content:

Signed________________________________ Date: ________________

CONSENT FOR TREATMENT

I hereby grant authority to Dr. Formaker to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed above:

Authorization must be signed by the patient, or by the custodial relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed________________________ Date: __________ Relationship to Patient: ______________