## Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____Age_____

Cell Phone _____ (Work): _____ Ext:_____ Home Phone _____

Preferred method of contact: (circle) cell text email home work

E-Mail address_____Drivers License #_____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer:_____

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

## Health History

Physicians's Name_____Phone_____Date of Last Visit_____

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

AIDS/HIV Positive
Anemia
Arthritis/Rheumatism
Artificial Heart Valve
Artificial Joints
Asthma
Back Problems
Blood Disease
Cancer/Chemotherapy
Chemical Dependency
Circulatory Problems
Cortisone Treatment
Chronic Cough
Diabetes
Epilepsy
Blood Thinners
Fainting/Dizziness
Glaucoma
Headaches
Heart Murmur
Heart Problems
Describe_____
Hepatitis
High Blood Pressure
HPV
Kidney Disease
Liver Disease
Mitral Valve Prolapse
Mental Disorders
Nervous Disorders
Osteoporosis
Pacemaker
**Pregnancy**
Due date:_____
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Shortness of Breath
Sinus Problems
Smoke/Chew
Stroke
Swelling Feet/Ankles
Thyroid Problems
Tuberculosis
Tumors
Ulcers
Venereal Disease
**Allergies**
Aspirin
Codeine
Anesthetic
Latex
Penicillin
Sulfa
Other_____

- Please list medications you are now taking: _____

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Emergency Contact: Name: _____Phone_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

## Dental History

Reason for today's visit_____

Date of last check-up/x-rays_____Former Dentist_____Phone_____

Circle if you have had problems with any of the following:

Bad Breath
Bleeding Gums
Clicking or popping jaw
Food collection between teeth
Sores or growth in your mouth
Grinding Teeth
Loose or broken teeth
Periodontal treatment
Sensitivity to cold
Jaw Pain
Snoring
Sensitivity to hot
Sensitivity to sweets
Sensitivity when biting

How often do you floss?_____How often do you brush?_____Are you fearful of dental treatment?_____
Is there anything you would like to change about the appearance/color of your teeth or smile? _____
_____

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #_____Birth Date:_____

Phone (Home):_____(Work):_____Ext:_____Best time to call:_____

Address_____Apt#_____

City_____State_____Zip_____

Employer_____

## Insurance Information

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Insured's Birth Date: _____ SS/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: _____

_____

**Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Insured's Birth Date: _____ SS/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: _____

_____

## Consent for Services and Financial Policy

We are committed to your dental care being successful. Please understand that payment for your care is considered part of that care. Please read the following information carefully. We ask that you read, agree to, and sign prior to any treatment.

- All patients must complete our patient information form before receiving treatment.
- Full payment is due at the time of service unless previous arrangements have been made.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient's account. We will complete the patient's 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.
- Estimated co-pay and deductible is due at the time of service.
- We accept cash, check, Visa, MasterCard, American Express and Discover Card.
- We offer an extended payment plan (Care Credit ) with prior credit approval.
- A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- There will be a charge for appointments missed without 24 hours notice.

Please let us know if you have any questions or concerns regarding this information.

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

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party