Patient Information

Patient Name: ____ Date:_____________
Last First MI

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

Social Security #: ____________________________ Birth Date:__________________Age_________

Phone (Home): ______________ (Work): ______________ Ext:______ Cell Phone:_______________

E-Mail address____

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
Glaucoma
Headaches
Heart Murmur
Heart Problems
Describe______________
Hepatitis
High Blood Pressure
Jaw Pain
Kidney Disease
Liver Disease
Mitral Valve Prolapse

Mental Disorders
Nervous Disorders
Pacemaker
Pregnancy
Due date:_________
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Rheumatism
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:

____

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

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: ______________________________

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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: ______________________________

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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