



Patient Information

Patient Name: _____ Date: _____
 Last First MI (Preferred Name)
 Gender: _____ Marital Status: _____
 Social Security #: _____ Driver's License #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____
 Home Address: _____ Mailing Address: _____
 Street Apartment #
 City State Zip Code

Health Information

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

Medical History and Medical Conditions

Have you ever had any of the following?

AIDS	yes no	Growths	yes no	Rheumatic Fever	yes no
Allergies	yes no	Hay Fever	yes no	Rheumatism	yes no
Alcohol/Drug Abuse	yes no	Head Injuries	yes no	Sinus Problems	yes no
Anemia	yes no	Heart Disease	yes no	Stomach Problems	yes no
Arthritis	yes no	Heart Attack/Surgery	yes no	Stroke	yes no
Artificial Joints/Valves	yes no	Heart Murmur	yes no	Tuberculosis	yes no
Asthma	yes no	Hepatitis A B C	yes no	Tumors	yes no
Blood Disease	yes no	High Blood Pressure	yes no	Ulcers	yes no
Cancer	yes no	Jaundice	yes no	Venereal Disease	yes no
Chemotherapy	yes no	Kidney Disease	yes no	ALLERGIES	
Diabetes	yes no	Liver Disease	yes no	Codeine Allergy	yes no
Insulin dependent	yes no	Mental Disorders	yes no	Penicillin Allergy	yes no
Diet/Exercise controlled	yes no	Nervous Disorders	yes no	Latex Allergy	yes no
Emphysema	yes no	Pacemaker	yes no	Tetracycline Allergy	yes no
Epilepsy	yes no	Currently Pregnant	yes no	Aspirin Allergy	yes no
Excessive Bleeding	yes no	Due Date: _____		Sulfa Allergy	yes no
Fainting	yes no	Radiation Treatment	yes no	Other Allergies:	
Glaucoma	yes no	Respiratory Problems	yes no		

- 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? 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: _____
- For Women: Are you taking birth control pills? Yes No Are you nursing? Yes No
- Please list any **MEDICATIONS** that you are currently taking and for what condition: _____

Referral Information

How did you hear about our office? _____
 Name of person or office referring you to our practice: _____
 Names of other family members seen in our office? _____

Reviewed by Dr. _____ **Date:** _____

Patient Name (please print): _____

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: _____ Cell: _____

Address: _____

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____

Insurance Information

Primary

Name of Subscriber: _____ Last _____ First _____ MI _____ Is Subscriber a patient? Yes No

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____

Subscriber's Employer Name: _____

Address: _____

Patient's relationship to Subscriber: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Subscriber: _____ Last _____ First _____ MI _____ Is Subscriber a patient? Yes No

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____

Subscriber's Employer Name: _____

Address: _____

Patient's relationship to Subscriber: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

Welcome to our office! Thank you for choosing us as your dental care provider. In order to better serve your needs, we feel it is important to understand our financial policy and our standard practices. 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 at the time services are performed.

Our practice is committed to providing the best treatment for our patients and our charges reflect what is usual and customary for our area.

Please help us to serve you better by: keeping scheduled appointments; providing advanced notice if changes are needed (a 24 hour notice is required); accompany any minor to dental appointments (under age 18 years); and after 2 missed appointments, we reserve the right to dismiss the patient from our practice.

We will be happy to provide you with an estimate for the treatment needed, however, this is simply an estimate and may not always be accurate. In some cases, when work is started, there are unseen repairs and/or conditions discovered, which could not be detected at the time of the original estimate. We must therefore assume no liability to perform services for prices quoted in original estimates and those prices are subject to change.

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. We will bill your insurance as a courtesy. We require that you provide the dental insurance information and advisement of subsequent insurance changes or requests. Your insurance policy is a contract between you and your insurance company.

A finance 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.

Please note that we are a multiple dentist practice, you may not be called for treatment in the order that you arrive.

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.

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.

X _____ Date: _____ Relationship to Patient: _____
Signature of Patient / Guardian / Responsible Party

I have received a DMFS X _____ I have received and understand the HIPPA sheet X _____