

Patient Information

Patient Name: _____ Date: _____
 Last, First MI (Preferred Name)
 Single ___ Married ___ Widowed ___ Separated ___ Divorced ___ Social Security # _____
 Birth Date _____ Age: _____ Male ___ Female ___ Best time to call: _____
 Phone (Home): _____ (Work): _____ Ext: _____ (Cell) _____ E-Mail _____
 Address: _____
 Street _____ Apartment # _____
 City _____ State _____ Zip Code _____
 How would you like us to contact you? Home ___ Work ___ Cell ___ E-Mail ___
 In Case of Emergency-Contact _____

If there was a simple inexpensive way to whiten your teeth, would you be interested? _____
 If you could change one thing about your smile, what would it be? _____
 What problems, if any, have you had with previous dental care? _____
 Date of Last Dental visit _____ Date of Last Dental X-Rays _____
 Reason for today's visit _____

Dental Health Information please check all that apply:

- Bad Breath
- Bleeding gums
- Blisters on lips or mouth
- Burning sensation on tongue
- Chew on one side of mouth
- Cigarette, pipe, or cigar smoking
- Clicking or popping jaw
- Dry mouth
- Fingernail biting

- Food collection between the teeth
- Foreign objects
- Grinding teeth
- Gums swollen or tender
- Jaw pain or tiredness
- Lip or cheek biting
- Loose teeth or broken fillings
- Mouth breathing
- Mouth pain, brushing
- Orthodontic treatment

- Pain around ear
- Periodontal treatment
- Sensitivity to cold
- Sensitivity to heat
- Sensitivity to sweets
- Sensitivity when biting
- Sores or growths in your mouth
- How often do you floss? _____
- How often do you brush? _____

Health Information

Please check those that apply:

- AIDS/HIV
- Anemia
- Arthritis/Rheumatism
- Artificial Joints
- Asthma
- Artificial Heart Valves
- Back Problems
- Bleeding abnormally, with extractions or surgery
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Congenital Heart Lesions
- Cortisone Treatments
- Cough, persistent or bloody

- Diabetes
- Dizziness
- Emphysema
- Epilepsy
- Excessive Bleeding
- Fainting or dizziness
- Glaucoma
- Growths
- Hay Fever
- Headaches
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis
- Herpes
- High Blood Pressure
- Jaundice
- Jaw Pain
- Kidney Disease
- Liver Disease
- Low blood pressure
- Mental Disorders
- Mitral Valve Prolapse

- Nervous Disorders
- Pacemaker
- Ever Taken Phen-Phen
- Psychiatric Care
- Pregnancy
Due date: _____
Nursing: _____
- Taking Birth Control Pills
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Sinus Trouble
- Skin Rash
- Special Diet
- Stomach Problems
- Stroke
- Swollen feet or ankles
- Swollen neck glands
- Thyroid Problems
- Tonsillitis

- Tuberculosis
- Tumors or growth on head or neck
- Ulcers
- Venereal Disease
- Weight Loss, unexplained
- ALLERGIES**
- Aspirin
- Barbiturates (sleeping pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin Allergy
- Sulfa
- OTHER:

- 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: _____
- List any medications you are currently taking and the correlating diagnosis _____

Pharmacy Name _____ Phone () _____

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 _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

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 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.

A service charge of 1 1/2% 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.

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, parent or guardian _____ Date: _____ Relationship to Patient: _____

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

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: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City, State Zip Code _____ Phone _____

Insurance Information

Primary Name of Insured: _____ Is insured a patient? Yes No

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

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

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

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

Insurance Plan Name and Address: _____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ____ YES ____ NO
For what conditions? _____
Are you taking any new medications? _____ If so, what _____
Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

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Patient's Signature _____ Date _____
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