Patient Information

Patient Name_____ M / F: _____ Date_____
Last, First MI (Preferred Name)

Birth Date: _____ Social Security #: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Emegency Contact: _____ Phone: _____

Health Information

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

☐ Acid Reflux/GERD	☐ Congenital Heart Disorder	☐ Kidney Disease	☐ Rheumatism
☐ AIDS	☐ Diabetes	☐ Leukemia	☐ Sinus Problems
☐ Alzheimer's Disease	☐ Dizziness	☐ Liver Disease	☐ Steroid Use
Allergies:	☐ Epilepsy	☐ Mental Disorders	☐ Stomach Problems
☐ **Penicillin**	☐ Excessive Bleeding	☐ depression	☐ Stroke
☐ **Codeine Allergy**	☐ Fainting	☐ Mitral Valve Prolapse	☐ Swelling of Limbs
☐ _____	☐ Fibromyalgia	☐ Nervous Disorders	☐ Tuberculosis
☐ Anaphylaxis	☐ Glaucoma		☐ Tumors
☐ Angioedema	☐ Growths	☐ **Osteoporosis list medications:**	☐ Ulcers
☐ Any Implants	☐ Hay Fever		☐ Venereal Disease
☐ Anemia	☐ Head Injuries		
☐ Arthritis	☐ Heart Disease	☐ Pacemaker	☐ OTHER:
☐ Artificial Joints	☐ Heart Murmur	**Pregnancy (present**	
☐ Asthma	☐ Hemophilia	**Due date:_____**	☐ **MRSA (antibiotic resistant staph)**
☐ Blood Disease	☐ Hepatitis	☐ Radiation Treatment	_____
☐ Cancer	☐ High Blood Pressure	☐ Respiratory Problems	
☐ Chemothearpy	☐ Jaundice	☐ Rheumatic Fever	
☐ Cold Sores			

Any Symptoms Of Covid 19 Such As Cough, Fever, Diarrhea, Headache, Sneezing? ☐ Yes ☐ No

Have You Traveled Recently? ☐ Yes ☐ No

Anyone In Your Household Exposed To A Person That Has Tested Positive For Covid19? ☐ Yes ☐ No

Have You Been Recently Hospitalized? ☐ Yes ☐ No

- Are you currently taking any medications/supplements? ☐ Yes ☐ No
  If yes, please list: _____
- 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 use any tobacco products? ☐ Yes ☐ No If so, how much? _____.

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: _____

Financially Responsible Party

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): _____ (Cell): _____

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

Last First MI

Insured's Birth Date: _____ ID #:or SS# _____

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

Yes No

_____

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.

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.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party