



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	
Emergency Contact: _____		Phone: _____	

Health Information

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

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

 Signature of patient, parent or guardian Date: _____

Referral Information
Whom may we thank for referring you to our practice? <input type="checkbox"/> Another patient, friend <input type="checkbox"/> Another patient, relative
<input type="checkbox"/> Dental Office <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> 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.

 Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

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