

Patient Information



(This information is necessary for our files and will be considered **CONFIDENTIAL**)

1

Name:		Home Phone: <i>Include area code</i>		Cell Phone: <i>Include area code</i>	
Last	First	Middle Init.	()	()	()
Spouse:				Your Business Phone: <i>Include area code</i>	
				()	()
Address:			City:	State:	Zip:
<i>Mailing address</i>					
Date of birth:	Age:	Sex: M F	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
			<input type="checkbox"/> Widowed	<input type="checkbox"/> Minor	
Social Security No.			Email Address		

DENTAL INSURANCE *Accurate insurance card required at time of service*

2

Should we assist in submitting insurance forms? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Primary Carrier * Please provide us with a copy of your insurance card.			
Plan No.	Insurance Carrier	Employee	D.O.B.
Relationship to Insured	Employee SS#	- -	Insurance ID No.

ACCOUNT INFORMATION

3

Preference of payment	<input type="checkbox"/> Cash on day of treatment	<input type="checkbox"/> Visa # _____	<input type="checkbox"/> Mastercard # _____
Person financially responsible for account		D.O.B.	
Name:	SS#:	Occupation:	
Employer:	Employer Address:	Business Phone: ()	

GETTING TO KNOW YOU

4

Is another member of your family or relative a patient at our office? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, their name:					
Who can we thank for referring you?					
Person or emergency contact:	Phone No:	Address:	City:	State:	Zip:
	()				
Closest relative not living with you:	Phone No:	Address:	City:	State:	Zip:
	()				

TERMS & CONDITIONS *Payment is due at time of treatment unless other arrangements have been approved.*

5

- As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.
- A service charge of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charge on the unpaid principal balance on all accounts not paid within 60 days of treatment.
- I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.
- In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, 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 fifteen (15) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.
- I grant my permission to you, or your assigns, 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 agree to their content.

Signed: _____ Relationship: _____ Date: _____

Health Questionnaire

Patient Name _____

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question. Place an (X) in the appropriate where applicable.

MEDICAL HISTORY

	Yes	No
1. Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>
2. Date of last physical examination _____		
3. Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what is the condition being treated? _____		
4. Have you ever had any serious illness or operation?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what illness or operation? _____		
5. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what was the problem? _____		
6. Are you taking any medicine?	<input type="checkbox"/>	<input type="checkbox"/>
or any recreational drugs (marijuana, cocaine, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what/ & what dosage? _____		
7. Do you use Tobacco	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been pre-medicated with antibiotics for your dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you sensitive or allergic to any drugs? <input type="checkbox"/> Penicillin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Other _____		
10. Do you wear a cardiac pacemaker, or have you had heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have any disease, condition or problem not listed (in Question #14) that you think I should know about?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what? _____		
12. (Women) Are you pregnant? <input type="checkbox"/> <input type="checkbox"/> If so, how many months? _____		
13. (Women) Do you take birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

14. Do you have or have you had any of the following:

	Yes	No	Yes	No	Yes	No
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	HIV	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	(AIDS)	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>
Joint Replacement ..	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>
Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	Artificial Prosthesis	<input type="checkbox"/>
Excessive Bleeding ...	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	Psychiatric Treatment .	<input type="checkbox"/>
High Blood Pressure ..	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	X-ray or Cobalt	
Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Treatment	<input type="checkbox"/>
Congenital Heart			Sinus Trouble	<input type="checkbox"/>	Fainting Spells or	
Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Difficulty in Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Chemotherapy	
Heart Ailments or			Stomach Ulcers ...	<input type="checkbox"/>	(Cancer, Leukemia) .	<input type="checkbox"/>
Attack	<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris ...	<input type="checkbox"/>	Radiation Treatment	
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorder ...	<input type="checkbox"/>	of any kind	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion .	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder ..	<input type="checkbox"/>	Other	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>		

DENTAL HISTORY

	Yes	No
1. Have you ever had an unfavorable reaction from a local anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a latex allergy?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you having pain or discomfort at this time?	<input type="checkbox"/>	<input type="checkbox"/>
4. Reason for this visit _____		
5. How long since your last full-mouth X-Rays? _____		
6. How long since your last dental treatment _____ What for? _____		
7. Do you feel very nervous about having dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If yes (X): <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Extremely		

	Yes	No
8. Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have headaches?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many per week?		
10. Are you satisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
if no, what would you change?		
12. Have you ever:		
<input type="checkbox"/> Worn Dentures <input type="checkbox"/> Worn Partial Dentures		
<input type="checkbox"/> Had Orthodontic Care or (Braces)		
<input type="checkbox"/> Had Periodontal Treatment (Gums) <input type="checkbox"/> Been treated for TMJ (Jaw Joint)		

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. Refusal of diagnostic aids at any future time will release Doctor of responsibility for early diagnosis. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand that the use of anesthetic agents embodies a certain risk. This consent shall remain in effect until cancelled.

8 Patient _____ Date _____ Witness _____
Parent or Responsible Party _____ Relationship to Patient _____

MEDICAL HISTORY UPDATES

Date _____	Comments _____	Signature _____
Date _____	Comments _____	Signature _____
Date _____	Comments _____	Signature _____