

# Patient Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ / \_\_\_\_\_  
Last First MI preferred name

\_\_\_ Male \_\_\_ Female \_\_\_ Married \_\_\_ Single \_\_\_ Child \_\_\_ Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street Apartment #

City State Zip code

Email Address: \_\_\_\_\_

Person/Telephone number to contact in an emergency: \_\_\_\_\_

# Health Information

Reason for today's visit: \_\_\_\_\_

What do you **not** like about your teeth or your smile?

\_\_\_ size \_\_\_ missing teeth \_\_\_ unattractive fillings  
\_\_\_ shape \_\_\_ mobile teeth \_\_\_ pain  
\_\_\_ color \_\_\_ alignment \_\_\_ unable to eat well  
\_\_\_ other: \_\_\_\_\_

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

___ AIDS	___ Anemia	___ Arthritis	___ Artificial joints
___ Asthma	___ Blood disease	___ Excessive Bleeding	___ Jaundice
___ Sinus Problems	___ Fainting	___ Kidney Disease	___ Stomach Problems
___ Glaucoma	___ Liver Disease	___ Stroke	___ Growths
___ Mental Disorders	___ Tuberculosis	___ Hay Fever	___ Nervous Disorders
___ Tumors	___ Head Injuries	___ Pacemaker	___ Ulcers
___ Cancer	___ Heart Disease	___ Radiation Treatment	___ Venereal Disease
___ Diabetes	___ Heart Murmur	___ Respiratory Treatment	___ Codeine Allergy
___ Dizziness	___ Rheumatic Fever	___ Penicillin Allergy	___ Mitral Valve Prolapse
___ Epilepsy	___ High Blood Pressure	___ Rheumatism	___ Sulfa Allergy
___ Hepatitis Type _____			

**Do you smoke or use smokeless tobacco?** \_\_\_\_\_ **Interested in quitting?** \_\_\_\_\_

**Pregnancy?** \_\_\_\_\_ **Due date?** \_\_\_\_\_

**Are you taking birth control pills?** \_\_\_\_\_ **(brand):** \_\_\_\_\_

**ARE YOU TAKING ANY ASPIRIN OR BLOOD THINNER ON A DAILY BASIS?** \_\_\_\_\_

**Have you taken, or are you currently taking any bisphosphonates such as Fosamax, Boniva, Actonel, etc.? If so List:** \_\_\_\_\_

**Medications currently taking:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_  
\_\_\_\_\_

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? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

Please list any surgeries you have had. \_\_\_\_\_

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: \_\_\_\_\_

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 doctor at the next appointment without fail.

Date: \_\_\_\_\_

Signature of patient, parent or guardian

### 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. \_\_\_\_\_

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

## 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. Therefore 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 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 1.5% 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 the reasonable value of when said services are rendered, or with 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 here under 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