PATIENT HISTORY

Patient Name			Date of Birth	ID: For Office Use Only
Address		Today's Date	Date of Last Visit	Date of Med Hx
Home Phone	Cell Phone	Work Phone	Social Security No	Marital Status
Primary Dental Guarantor		Home Phone	Cell Phone	Work Phone
Secondary Dental Guarantor		Home Phone	Cell Phone	Work Phone
Physician Name			Physician Phone	
Pharmacy Name			Pharmacy Phone	

List Medications:	Circle If Allergic to: Latex, Metal, Penicillin, Erythromycin, Aspirin, Codeine, Dental Anesthetics, Jewelry List Other Allergies:

Sex: M F	If Female Please answer the following:		
	Are you taking birth control pills?	Y N	
	Are you pregnant?	Y N	Number of Weeks:
	Are you nursing?	Y N	

Please circle if you ever had any of the following CONDITIONS			
Abnormal Bleeding	Cancer	Glaucoma	Pace Maker
Alcohol Abuse	Chemotherapy	HIV or AIDS	Pain in Jaw
Allergies	Congenital Heart Defect	Heart Attack	Psychiatric Problems
Anemia	Developmental Delay	Heart Murmur	Radiation Therapy
Angina Pectoris	Diabetes	Heart Surgery	Shingles
Arthritis	Difficulty Breathing	Hemophilia	Sickle Cell Disease
Artificial Bones	Drug Abuse	Hepatitis A, B or C	Sinus Problems
Artificial Heart Valve	Emphysema/COPD	High Blood Pressure	Stroke
Asthma	Epilepsy/ Seizures	Joint Replacement	Thyroid Problems
Autism	Fainting Spells	Kidney Problems	Tuberculosis
Blood Transfusion	Fever Blisters	Liver Disease	Ulcers
Bruise Easily	Frequent Headaches	Mitral Valve Prolapse	
List other Medical Problems not circles above			

F or Office Use Only **Medical Alerts:**

TERMS & CONDITIONS

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 cost 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 prior financial arrangements, must be paid in cash at 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 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 date. In consideration of the professional services rendered to me, 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 five (5) 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 proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasonable attorney fees.

I grant permission to you, or your assigns, to telephone me at home or my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signed ____ Date _____________

FINANCIAL INFORMATION

Person responsible for this account ____________________________Relationship________________

Address____

Street City Zip Telephone

PERFERNCE OF PAYMENT: Cash on day of treatment Check Visa Mastercard

Employed by ____Occupation __________________

Name of Primary Insurance _________________________________Group# ___________________

Insured Person Name____________________________

Birthdate _____________Relationship_______________Social Security # _______________

Name of Secondary Insurance________________________________Group#____________________

Insured Person Name____________________________

Birthdate _____________Relationship_______________Social Security # _______________

CONSENT FOR TREATMENT

I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and condition printed above

Signed ____Date__________________

Authorization must be signed by the patient or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent

Relationship to patient: Self Mother Father Foster Parent Legal Guardian Other ___________