Chart #:__________
FOR OFFICE USE ONLY

## Patient Information

Patient Name: ________________________________________ Date:__________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: ____________________ Birth Date:____________________

Phone (Cell): ______________ (Home)__________(Work): ______________

Email________________________________________

Address: ________________________________________
Street Apartment #

________________________________________
City State Zip Code

## Health Information

Date of Last Dental Visit: __________ Reason for this visit:____________________

Previous Dentist: ______________ Physician:____________________

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

☐ AIDS
☐ HIV
☐ Allergies
☐ Diabetes
☐Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Lung Conditions
☐ Dizziness
☐ Dry Mouth
☐ Ear pain
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Gum disease
☐ Hay Fever
☐ Head Injuries
☐ Headaches
☐ Heart Disease
☐ Heart Murmur
☐ Heart Conditions
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pain in Jaws
☐ Pacemaker
☐ Pregnancy
Due date:__________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Shortness of breath
☐ Sinus Problems
☐ Snore
☐ Stomach Problems
☐ Stroke
☐ Swollen Joints
☐ Tobacco user
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Sulfa Allergy

•Please list any surgeries you have had in the past. (Major illness, diseases, or other diagnosis we should know about)

________________________________________

________________________________________

• Please list all medications and over the counter meds you are currently taking

________________________________________

________________________________________

•Have you ever had any complications following dental treatment? ☐ Yes ☐ No

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

• Are you now under the care of a physician? ☐ Yes ☐ No

• Do you have any health problems that need further clarification? ☐ Yes ☐ No

• Have you ever been told you need to take a Premedication before any dental work? ☐ Yes ☐ No

• If you could change anything about your smile, what would it be?_______________________________________

• Do you think your teeth are affecting your general health in any way? ☐ Yes ☐ No

• Do you have trouble opening your mouth wide? ☐ Yes ☐ No

• Do you drink fluoridated water? ☐ Yes ☐ No

• Do you bleed for a long time when you cut yourself? ☐ Yes ☐ No

• I have been told that I stop breathing when I sleep, although I may have no recollection of this. ☐ Yes ☐ No

• I am sleepy during the day even if I slept throughout the night. ☐ Yes ☐ No

•I have been told that I sleep restlessly, I am always "tossing" and "turning" while asleep. ☐ Yes ☐ No

• I tend to sweat excessively during my sleep. ☐ Yes ☐ No

• I frequently awaken with headaches in the morning. ☐ Yes ☐ No

•I tend to fall asleep during inappropriate times. ☐ Yes ☐ No

• I am overweight. ☐ Yes ☐ No

•Others and/ or I have noticed a recent change in my personality. ☐ Yes ☐ No

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:__________________________________________________

## Emergency Information

Name: ____________________

Social Security #: ____________________ Birth Date: ____________________

Phone (Cell): __________ (Home): __________(Work):__________ Email: __________

Address: ____________________
Street Apartment #

____________________
City State Zip Code

## Employment Information

Employer Name: ____________________ Occupation: ____________________

Address: ____________________
Street City State Zip Code

## Insurance Information

**Primary**

Name of Insured: ____________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: __________ ID #: __________ Group #:__________

Insured's Address: ____________________
Street City State Zip Code

Social Security #: ____________________ Birth Date: ____________________

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**

Name of Insured: ____________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: __________ ID #: __________ 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: ____________________

____________________

## 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.

A service charge of 1½% 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 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