

## Patient Information

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last, First MI (Preferred Name)

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Driver's License # \_\_\_\_\_ Gender: M / F \_\_\_\_\_ Family Status : \_\_\_\_\_

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

Address: \_\_\_\_\_  
Street Apartment # City Zip Code

Emergency Name and Phone \_\_\_\_\_

Pharmacy # (\_\_\_\_) \_\_\_\_\_

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

## Employment Information

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State Zip Code

Phone \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice?

Another patient  Dental Office  Internet Search  Website  School  Work  Other \_\_\_\_\_

Name of person/address or office referring you to our practice: \_\_\_\_\_

\_\_\_\_\_

## Health Information

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

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> AIDS / HIV<br><input type="checkbox"/> <b>Allergies</b><br>_____<br>_____<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> <b>Artificial Joints</b><br><input type="checkbox"/> Asthma<br><input type="checkbox"/> <b>Bleeding Gums</b><br><input type="checkbox"/> Blood Disease<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Chemotherapy<br>dates: _____<br><input type="checkbox"/> Defibrillator<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Excessive Bleeding<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Growths<br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Head Injuries<br><input type="checkbox"/> <b>Heart Disease</b><br><input type="checkbox"/> <b>Heart Murmur</b><br><input type="checkbox"/> <b>Stent/ Valve Replacement</b><br><input type="checkbox"/> Hepatitis<br>Type : _____<br><input type="checkbox"/> HPV –Human Papilloma Virus | <input type="checkbox"/> Jaundice<br><input type="checkbox"/> Jaw Joint problems<br><input type="checkbox"/> Joint Replacement<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Mental Disorders<br><input type="checkbox"/> Nervous Disorders<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> <b>Pregnancy</b><br>Due date: _____<br><input type="checkbox"/> Radiation Treatment<br><input type="checkbox"/> Respiratory Problems<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Rheumatism<br><input type="checkbox"/> Sinus Problems<br><input type="checkbox"/> Sleeping Problems<br><input type="checkbox"/> Snoring Problem<br><input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke<br><input type="checkbox"/> <b>STD</b><br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Tumors<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Venereal Disease<br><input type="checkbox"/> Codeine Allergy<br><input type="checkbox"/> <b>Penicillin Allergy</b><br><input type="checkbox"/> <b>Latex Allergy</b><br><input type="checkbox"/> <b>Drug Allergy</b><br>_____<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____ |
|---|--|--|--|

**Do you require any form of pre- med ( ANTIBIOTICS) for dental treatment ?** \_\_\_\_\_

• **Are you currently taking any Medications/ Vitamins/ Herbs? 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 have any health problems that need further clarification?**  Yes  No

No  
 If yes, please explain: \_\_\_\_\_

• Do you have headaches ?  Yes  No  
 If yes how often and where ? \_\_\_\_\_

• Do you have Sleep Apnea ?  Yes  No  
 If yes, do you wear a C-Pap ?  Yes  No  
 Have you ever had a Sleep Study completed ?  Yes  No  
 Dates : \_\_\_\_\_ Location \_\_\_\_\_ Physician : \_\_\_\_\_

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. I also understand that I am responsible for all charges and late fees.

\_\_\_\_\_  
 Signature of patient, parent or guardian Date: \_\_\_\_\_



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 LATE FEE 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: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient, parent , guardian or guarantor

Relationship to Patient: \_\_\_\_\_