Patient Information

Patient Name: _____ **Date**: _____
Last, First MI (Preferred Name)

Gender: _____ **Family Status**: _____ **Birth Date**: _____

Social Security #: _____ ***Drivers License***: _____

Phone (Home): _____ **(Work):** _____ **Ext**: _____

Cell Phone: _____ E**mailAddress:** _____

Address: _____
Street (If P.O. Box, please include street address) Apartment #

_____ _____
City State Zip Code

EMERGENCY Contact Person: _____ **Relation:** _____ **Phone #:** _____

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:** _____ **Best time to call:** _____

Address: : _____
Street (If P.O. Box, please include street address) 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 Phone

Dental Insurance Information

Primary Dental Insurance:

Insurance Plan Name and Address: _____

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 _____

Secondary Insurance Information

Insurance Plan Name and Address: _____

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: _____
Name Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient Name:_____ Date of Birth:_____

Health Information

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

- ☐ AIDS/HIV Infection
- ☐ Allergies(seasonal)
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy/Convulsions
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting/Seizures
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Leukemia
- ☐ Mental Disorders
- ☐ **Pregnancy (current)** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Tumors
- ☐ Thyroid Problem
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ **Artificial Joints**
- ☐ **Heart Attack**
- ☐ **Heart Disease**
- ☐ Heart Murmur
- ☐ **Hepatitis**
- ☐ **Mitral Valve Prolapse**
- ☐ **Stroke**
- ☐ **Take Blood Thinners**
- ☐ **Take Aspirin Daily**
- ☐ Other:_____

Please list any medications that you are currently taking:_____

- Are you allergic or have you had any reactions to the following? If yes, please check box

  ☐ **Penicillin Allergy** ☐ **Sulfa Drugs** ☐ **Codeine Sensitivity** ☐ **Barbiturates** ☐ **Aspirin**
  ☐ **Latex Allergy** ☐ **Local Anesthetics(eg. Novocaine)** ☐ **Other** _____

- **Have you been instructed to take medication prior to your dental appointment?**_____

- **Do you have a recent onset of a respiratory problem like cough or difficulty breathing?** ☐ **Yes** ☐ **No**

- **Do you have a fever?** ☐ **Yes** ☐ **No** **Have you ever had heart surgery or under a physicians care for your heart?** ☐ **Yes** ☐ **No** What? _____ When?_____

- 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
  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 doctors at the next appointment without fail.

_____ **Date:** _____
PRINT NAME of patient, parent or guardian

_____ **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: _____

COSMETIC INFORMATION

Is there anything about your smile that you do not like?_____

Are you interested in the options available for a more beautiful smile?_____

Do you have any old fillings or dental treatment that you are not happy with?_____

Do you like the appearance of your teeth?_____ Are all of your teeth in alignment (straight)?_____

Do you have any missing teeth?_____ Are any chipped?_____

Is your bite comfortable when chewing, biting?_____ Do you have frequent headaches?_____

What would you like to change the most about the appearance of your teeth?_____

Is there anything else you would like us to know?_____

Dental History

Please check those that apply :

☐ Bad Breath ☐ Bleeding Gums ☐ Periodontal Treatment ☐ Gums swollen or tender

☐ Grinding teeth ☐ Clicking or popping jaw ☐ Lip or cheek biting ☐ Food collection between teeth

☐ Dry Mouth ☐ Mouth Breathing ☐ Cold sores/Fever blisters ☐ Loose teeth or broken fillings

Sensitivity to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting ☐ Orthodontic Treatment

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.

I understand that the fee estimate listed for this dental care can only be extended for a period of three 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 fees associated with 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 fees associated with said services shall be paid in full within 45 days of said services irregardless of any estimated insurance benefits. 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 collection cost and if suit be instituted hereunder all reasonable attorney fees.

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 also authorize the release of my dental records and medical records relevant to dental treatment, or copies of such.

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

_____ **Date**: _____ **Relationship to Patient**: _____

Print name of patient, parent or guardian

_____ **Date**: _____ **Relationship to Patient**: _____

Signature of patient, parent or guardian