We thank you for selecting us to provide dental care for you and your family. We will do our best to keep your trust.

PLEASE PRINT LEGIBLY

Patient Information

Patient Name: ________________________________ Date:______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other Social Security #: ________________

Birth Date_________ Driver's License #: _________________________ E-Mail Address: ______________________

Home Phone ________________ Work________________ Ext ______ Best time to call_____________

Cell__________________ Fax _________________Other ________________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐Mon ☐Tues ☐Th ☐Fri ☐Sat

Address: ____
Street Apartment #

____
City State Zip Code

If patient is a full-time student, fill in school name and address: _____________________________________

Emergency Contact: ______________________________________ Phone # ________________________

Health Information

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

- ☐ AIDS
- ☐ Allergies __________ __________
- ☐ Allergic to Epinepherine
- ☐ Allergy to Latex
- ☐ Allergies to Meds ___________________ ___________________
- ☐ Allergy to Metal
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Codeine Allergy
- ☐ Cold Sores / Fever Blisters
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug or Alcohol dependence
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head aches
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Hypoglycemia
- ☐ Jaw Pain
- ☐ Insulin
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Nervousness
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ **Pregnant** Due date:_________
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stress
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:
- ☐ __________________
- ☐ __________________

List Any Medications:

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ____________________

• 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
Name of Physician: ____________________ Phone:__________

•Are you currently taking any medication or drugs? ☐ Yes ☐ No
If yes, please explain: ____________________

•Have you taken any medication or drugs in the past two years? ☐ Yes ☐ No
If yes, please explain: ____________________

•Are you sensitive or allergic to any medication or anesthetics? ☐ Yes ☐ No
If yes, please explain: ____________________

FOR WOMEN ONLY:

Are you Pregnant? ☐Yes ☐ No. If yes, what month? __________
Are you Nursing? ☐Yes ☐No.
Are you taking Birth Control? ☐Yes ☐No

Dental Information

	Frequently	Occasionally	Never
Do your gums bleed when you brush?	________	________	________
Are your teeth Sensitive to heat or cold?	________	________	________
Are your teeth sensitive to pressure?	________	________	________
Are your teeth sensitive to sweet?	________	________	________
Do you grind or clench your teeth?	________	________	________

Do you have any fear of dental work? ☐Yes ☐No
Date of last Dental Exam: __________ What was done at the time? __________
Former Dentist Name: ____________________
How would you describe your current dental condition? ____________________
How do you feel about the appearance of your teeth? ____________________

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

Reviewed by:

____________________ Date:__________
Signature of Dr. or Hygientist

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:____

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #:_____________________

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Phone #: ________________________

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 Employer Name: ____

Address: ____

Street City State Zip Code

Phone #: ________________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________

Insurance Plan Name and Address: ____

____

Flex spending no ___ yes___ amount_________ Health Reimbursement no ___ yes___ amount_________

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