Patient Information

Patient Name: ____Date:_________________

Last First MI Preferred Name

Address:____

Street Apartment #

____

City State Zip Code

Employer: ____ Occupation: ___________________________

Family Status: ☐ Married ☐ Divorced ☐ Single ☐ Child ☐ Other:____

Social Security #:___________________________ Birth Date: ____________________ Gender: ☐ Male ☐ Female

Phone: Home ___________________ Work ___________________ ext.____ Cell: ______________________

Other: ___________________ Which number would you like us to use for appointment reminders? __________________

Email Address: ____

I agree to receive emails from the practice ☐ Yes ☐ No

Spouse, Parent, or Responsible Party Information

The following is for: ☐ Spouse ☐ Patient's Parent/Guardian ☐ Person Responsible for Payment

Name: ____Employer:_____________________________________

Social Security #:___________________________ Birth Date: ____________________ Gender: ☐ Male ☐ Female

Phone: Home ___________________ Work ___________________ ext.____ Cell: ____________________

Address:____

Insurance Information

Name: ____ Is subscriber a patient? ☐ Yes ☐ No

Subscriber Birth Date: _______________ Social Security #:_______________________Group# ___________________

Subscriber's Address: ____

Subscriber's Employer/Address: ____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________________

Insurance Co Name______________________________________ Insurance Co Phone _________________________

Insurance Co Address ____

Consent for Services (Read Carefully)

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 the insurance companies and will credit any such collections to the patients 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 1 1/2 % per month (18% per annum) on the unpaid balance may 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 30 days from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or my work or cell 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 ________________________
Signture of Guarnator of Payment/Responsible Party

How did you hear about our practice?

☐ Friend, relative, neighbor, etc. ☐ Another dentist ☐ Post Card ☐ Social Media ☐ Internet ☐ Sign/Drive-by

So we may thank them, please provide name of person or dentist who referred you:___________________________________

MEDICAL HISTORY

PATIENT NAME: ______________________________ Date: ________________

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
Heart (Surgery, Disease, Attack)….	Yes No	Emphysema…………………...	Yes No	Venereal Disease…………….	Yes No
Chest Pain…………………..	Yes No	Chronic Cough………………..	Yes No	H.I.V. Positive………………	Yes No
Congenital Heart Disease…..	Yes No	Cancer………………………..	Yes No	A.I.D.S………………………	Yes No
Heart Murmur………………	Yes No	Tuberculosis…………………..	Yes No	Blood Transfusion…………...	Yes No
High Blood Pressure………..	Yes No	Asthma………………………..	Yes No	Hemophilia…………………..	Yes No
Mitral Valve Prolapse………	Yes No	Hay Fever……………………..	Yes No	Sickle Cell Disease………….	Yes No
Artificial Heart Valve……….	Yes No	Sinus Trouble…………………	Yes No	Neurological Disorders……...	Yes No
Heart Stint/Shunt……………	Yes No	Allergies or Hives……………	Yes No	Epilepsy or Seizures………...	Yes No
Heart Pacemaker……………	Yes No	Latex Sensitivity……………...	Yes No	Fainting or Dizzy Spells…….	Yes No
Rheumatic Fever……………	Yes No	Radiation Therapy……………	Yes No	Nervous/Anxious……………	Yes No
Arthritis/Rheumatism……….	Yes No	Chemotherapy………………...	Yes No	Psychiatric Care……………..	Yes No
Stroke……………………….	Yes No	Tumors………………………..	Yes No	Cold Sores…………………...	Yes No
Artificial Joints……………...	Yes No	Hepatitis A ………..…………	Yes No	Fever Blisters………………..	Yes No
Kidney Trouble……………..	Yes No	Hepatitis B ……..……………	Yes No	Allergy to Jewelry/Metal……	Yes No
Diabetes……………………..	Yes No	Hepatitis C …………………...	Yes No	TMJ Disorder………………..	Yes No
Thyroid Problems…………...	Yes No	Liver Disease……………………..	Yes No	Smoke/Chew Tobacco………	Yes No
Osteoporosis………………...	Yes No	Headaches…………………….	Yes No	Jaw/Ear Pain………………...	Yes No

What is the reason for your visit today? ____

Date of your last Cleaning? ______________________ Last Full Mouth Set of X -rays? ______________________

Do you have any health problems that need further clarification? ………………………………………………….. Yes No
If yes, please explain ____

Do you have or have you had any disease, condition or problem not listed? …………………………………………. Yes No
If yes, please list ____

Are you under the care of a physician? …………………………………………………………………………… Yes No
If yes, please explain ____
Name of physician ____

Are you taking any medication, drugs or pills now? ………………………………………………………………. Yes No
If yes, please list: ____
____

Are you aware of having an allergy (or adverse reaction) to any medication or substance? ……………………….. Yes No
If yes, please list: ____

Have you ever been diagnosed with Periodontal "Gum" disease? …………………………………………………. Yes No
If yes, date of treatment____

Women : Are you: Pregnant? No...Yes ___Months Nursing ? No….Yes Taking Birth Control Pills ? No…. Yes

Doctor Signature: ______________________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (Name of Patient) ________________________'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication necessary. I fully understand that using anesthetic agents embodies certain risks; I understand that I can ask for a complete recital of any possible complications.

Patient ______________________________ Date __________ Witness ______________________

Parent or Responsible Party ______________________________ Relationship to Patient ______________________

Medical Information Release Form (HIPAA Release Form)

Name: ____ Date of Birth: ____/____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ☐ Spouse ____
- ☐ Child(ren) ____
- ☐ Other(s)____

☐ Information is not to be released to anyone.

This ***Release of information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number:___________________

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ leave a message asking me to return your call
- ☐ Other instruction: ____

The best time to reach me is (day)____________________ between (time)_________

Signed: ____ Date: ____/____/_____

Witness:____ Date: ___/____/______