

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Last First MI Preferred Name

Street Apartment #

City State Zip Code

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

Family Status:  Married  Divorced  Single  Child  Other: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender:  Male  Female

Phone:  Cell \_\_\_\_\_  Home \_\_\_\_\_  Work \_\_\_\_\_

*Please check number to be used for appointment reminders*

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

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

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 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 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.

\_\_\_\_\_  
Signature of Patient, Parent, or Guardian Date: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

\_\_\_\_\_  
Signature of Guarantor of Payment/Responsible Party Date: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

### How did you hear about our practice?

Friend, relative, neighbor, etc.  Another dentist  Post Card  Mailbox Flyer  Internet  Sign/Drive-by

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

**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please check all of the medical conditions/situations that apply to you.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Tuberculosis              | <input type="checkbox"/> AIDS                     |
| <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Blood Transfusion        |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Kidney Trouble              | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Blood Thinners           |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Kidney Stent/Shunt          | <input type="checkbox"/> Sinus Trouble             | <input type="checkbox"/> Hemophilia               |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Allergies or Hives        | <input type="checkbox"/> Sickle Cell Disease      |
| <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Thyroid Problems            | <input type="checkbox"/> Latex Sensitivity         | <input type="checkbox"/> Neurological Disorder    |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> Epilepsy or Seizures     |
| <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> History of Bisphosphonates? | <input type="checkbox"/> Hepatitis A/B/C           | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Nervous/Anxious          |
| <input type="checkbox"/> Heart Stent/Shunt        | <input type="checkbox"/> Chronic Cough               | <input type="checkbox"/> Venereal Disease          | <input type="checkbox"/> Psychiatric Care         |
| <input type="checkbox"/> Heart Pacemaker          | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> HPV Diagnosis             | <input type="checkbox"/> TMJ Disorder             |
| <input type="checkbox"/> Sleep Apnea              | <input type="checkbox"/> Radiation Therapy           | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Smoke/Chew/Vape Tobacco  |
| <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> Chemotherapy                | <input type="checkbox"/> HIV Positive              | <input type="checkbox"/> Jaw/Ear Pain             |
| <input type="checkbox"/> Arthritis/Rheumatism     | <input type="checkbox"/> Tumors                      | <input type="checkbox"/> Glaucoma                  |   |

Do you have any artificial joints?  No  Yes → Please tell us which joint(s) and what year you got it/them \_\_\_\_\_Do you have or have you had any disease, condition, or problem not listed above?  No  Yes → Please list \_\_\_\_\_Are you under the care of a physician?  No  Yes → Please explain \_\_\_\_\_

Name of Physician \_\_\_\_\_

Are you taking any medication, drugs, or pills now?  No  Yes → Please list \_\_\_\_\_Are you aware of having an allergy (or adverse reaction) to any medication or substance?  No  Yes → Please list \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Date of Last Cleaning? \_\_\_\_\_ Date of Last Full Set of X-Rays? \_\_\_\_\_

Have you ever been diagnosed with periodontal "gum" disease?  No  Yes → Date of treatment \_\_\_\_\_

What is your goal in seeking dental care? Please check all that apply

- 
- Prevent problems
- 
- Maintain current oral health
- 
- Fix cosmetic problems
- 
- Resolve pain only

**WOMEN:** Are you pregnant?  No  Yes → \_\_\_\_\_ Months      Are you nursing?  No  YesAre you taking birth control pills?  No  Yes

Doctor Signature: \_\_\_\_\_

I understand that the information above 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 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 the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of \_\_\_\_\_ (Patient Name)'s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutual 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 \_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_