

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)

Gender: \_\_\_\_\_ Family Status:  Married  Single  Child  Other «FamPos» \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

E-mail: \_\_\_\_\_ Mobile Phone/Pager: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

\_\_\_\_\_ City State Zip Code

### Employment or School Information

The following is for:  employment  school if patient is a student

Employer (School) Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

### Spouse or Responsible Party Information

Check here if patient is the responsible party and move to the next section.  
 The following is for:  the patient's spouse  the patient's parent  other person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

\_\_\_\_\_ City State Zip Code

### Insurance Information

**Primary**  
 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 \_\_\_\_\_

Insurance Plan Name and Phone: \_\_\_\_\_

Insurance Plan Address: \_\_\_\_\_

**Secondary**  
 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 \_\_\_\_\_

Insurance Plan Name and Phone: \_\_\_\_\_

Insurance Plan Address: \_\_\_\_\_

### Referral Information

How did you hear about us?  Another patient Name; \_\_\_\_\_  
 Sign  Insurance  Val-Pak  Flyer  Internet  Phone Book  Family comes here  Other \_\_\_\_\_

### Health Information

• Are you allergic to any of the following (please check all that apply):  Yes  No  
 Penicillin;  Tetracycline;  Sulfa Drugs;  Aspirin;  Codeine;  Latex;  Metals;  Dental Anesthetics;  Other

**Have you ever had any of the following? Please answer Yes or No to each question by marking the boxes below.**

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Dizziness/Fainting
<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Growths/Tumors	<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Mental Disorders
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Hepatitis Type:	<input type="checkbox"/> <input type="checkbox"/> Anxiety
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints	<input type="checkbox"/> <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Drug Addiction
<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Head Injuries
<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> <input type="checkbox"/> Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Cold Sores
<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> <input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> <input type="checkbox"/> Bruise Easily	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease	<input type="checkbox"/> <input type="checkbox"/> TMJ
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints

• Do you have any other health problems or conditions?  Yes  No  
 If yes, please explain: \_\_\_\_\_

• Are you taking any medications at this time?  Yes  No  
 If yes, please list : \_\_\_\_\_

• 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: \_\_\_\_\_

Fax: \_\_\_\_\_

• Do you smoke?  Yes  No If Yes, How much? \_\_\_\_\_

• Have you ever taken any diet drugs such as Phen-Phen, Redux, other?  Yes  No \_\_\_\_\_

• Women: are you pregnant now?  Yes, Due Date: \_\_\_\_\_  No

• Do you take any birth control medication?  Yes  No

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 have received a copy of the Dental Materials Fact Sheet dated October 2001.

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

## Dental History

Date of last dental visit: \_\_\_\_\_ Name of previous dentist: \_\_\_\_\_

Why are you changing dentists? \_\_\_\_\_

Reason for today's visit: (check all that apply)  Check-up  Cleaning  Pain  Other (use space below)

Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you ever had an unfavorable reaction to dental anesthetic?  Yes  No

Does dental treatment make you nervous?  No  Yes, Slightly  Yes, Moderately  Yes, Extremely

Do your gums bleed when you brush or floss your teeth?  Yes  No  Occasionally

Do you like your smile?  Yes  No If you could change your smile, what would you like to change?

I am interested in (check all that apply):  Teeth Whitening  Cosmetic Evaluation  Replacement of Missing Teeth

Breath Control  Sedation  White (Natural) Fillings  Home Care  Other \_\_\_\_\_

## Consent for Services

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this form, to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient; and to administer such anesthetics, sedatives, and nitrous oxide sedation as advisable in the treatment of this patient.

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. By signing this document, I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under the policy. I understand that the fee estimate listed for this dental case and any insurance authorizations are not a guarantee of payment from the insurance company and all fees may become my responsibility in the event that insurance company denies benefits. 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 collection and/or 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.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_