

PATIENT INFORMATION

Date: _____

Patient Name: _____ Preferred _____
Last First MI

Male Female

Birthdate _____ Age _____ Child Single Married Divorced Widowed

Address: _____
Street Apartment #
City State Zip Code

Driver's License: _____
State Number

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext: _____

Email: _____

**WHEN CONFIRMING AND/OR REMINDING YOU OF YOUR APPOINTMENT:
WOULD YOU PREFER: TEXT MESSAGING _____ EMAIL _____ OR BOTH _____**

RESPONSIBLE PARTY:

Name: _____ Relationship to Patient: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext: _____

INSURANCE INFORMATION:

Primary Insurance Plan: _____

Employer: _____

Subscriber's Name: _____ DOB _____

Social Security # _____ Member # _____

Patient's Relationship to Subscriber: Self Spouse Child Other

Secondary Insurance Plan: _____

Employer: _____

Subscriber's Name: _____ DOB _____

Social Security # _____ Member # _____

Patient's Relationship to Subscriber: Self Spouse Child Other

HEALTH INFORMATION

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

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bleeding Excessive | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis | |

Women: Are you pregnant? _____ Due Date _____ Are you nursing? _____

Are you now under the care of a physician? YES NO

If yes, please explain: _____

Name of Physician _____ Phone _____

Have you ever been told to pre-medicate with antibiotics before your dental appointment? _____

MEDICATIONS: List any medications you are currently taking

ALLERGIES: Please circle those that apply and list any others.

Aspirin Anesthetic Codeine Iodine Latex Penicillin Sulfa

Pharmacy Name: _____ Phone _____

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.

Signature of patient, parent or guardian

Date

CONSENT FOR SERVICES AND OFFICE POLICIES

The undersigned hereby authorized Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connect ion with patient and further authorize and consent the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agent embodies a certain risk. For minor consent, I do hereby request and authorize the dental staff to perform necessary dental services for my child and perform administrations of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

WARRANTY ON CROWN, BRIDGE OR IMPLANT

For a period of one (1) year from the date of service, we will remake the crown or bridge due to breakage or misfit at no cost to the patient.
All warranties will be null and void if the patient does not maintain his/her regular three, four or six month hygiene or periodontal maintenance appointments.

FINANCIAL POLICY:

I acknowledge that full payment is due at the time of treatment for all services rendered. I understand that full responsibility for payment of all dental services in this office for myself and my dependents is mine. I accept full financial responsibility for all charges whether or not paid by my dental insurance company.

Patients who carry dental insurance understand that all dental services furnished are ultimately the responsibility of the patient and that he/she is personally responsible for payment of all dental services. As a courtesy, this office will submit claims to your primary and secondary insurance. 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 30 days, unless previous written financial arrangements are satisfied.

CANCELLATIONS:

We do charge \$45 for those appointments that are cancelled or broken with less that 24 hour notice. We do understand emergencies do arise and we will try and work with you in those situations, but we would appreciate it if you would call our office as soon as possible if you need to cancel or reschedule an appointment.

I have read the above conditions of treatment and payment and agree to their content.
I have also read a copy of this office's Notice of Privacy Practices.

Signature of responsible party

Date

Relationship to Patient

Patient's Name _____

- | | | |
|--|-----|----|
| 1. Do you fear coming to the dental office? | YES | NO |
| 2. Do you have any present dental complaints? | YES | NO |
| 3. Are your teeth sensitive to: Heat Cold Sweets Biting Pressure | YES | NO |
| 4. Does food catch between your teeth? | YES | NO |
| 5. Do your gums bleed when brushing? | YES | NO |
| 6. Have you noticed swelling around any teeth? | YES | NO |
| 7. Do you have an unpleasant taste or odor in your mouth? | YES | NO |
| 8. Do you ever a void any part of your mouth when brushing? | YES | NO |
| 9. Would you be interested in getting screened for Oral Cancer? | YES | NO |
| 10. Do you like the appearance of your teeth and smile? | YES | NO |
| 11. Would you be interested in bleaching your teeth? | YES | NO |

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE.