PATIENT INFORMATION

DATE ________________

NAME ____ PREFERRED NAME: ______________

LAST *FIRST* *MI*

BIRTH DATE ___________________________ □MARRIED □SINGLE □MINOR □MALE □FEMALE

MONTH *DAY* *YEAR*

SOCIAL SECURITY #____________________________________

ADDRESS ____

STREET *APT. #* *CITY* *STATE* *ZIP*

I would like my appointments confirmed by: Email: □Yes □No

Text Message: □Yes □No

Email: _______________________________ Cell #: _______________________________________

Home #:______________________________ Work #: ______________________________________

Employer: ____________________________ Occupation: __________________________________

Whom may we thank for referring you to our practice? _______________________________________

Reason for this visit: ____

DENTAL INSURANCE INFORMATION

PRIMARY INSURED

Name: ____ **Birth Date:** ______________________

LAST *FIRST* *M* *(MO/DAY/YEAR)*

Employer Name: __________________________________ **SS#:** ____________________________

Insurance Plan Name: ______________________________ **Group#:** _________________________

Patient's relationship to insured: □ **Self** □**Spouse** □**Child** □**Other** __________________

SECONDARY INSURED

Name: ____ **Birth Date:** ______________________

LAST *FIRST* *M* *(MO/DAY/YEAR)*

Employer Name: __________________________________ **SS#:** ____________________________

Insurance Plan Name: ______________________________ **Group #:** ________________________

Patient's relationship to insured: □ **Self** □**Spouse** □**Child** □**Other** __________________

RESPONSIBLE PARTY INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT: □PATIENT □GUARDIAN □SPOUSE □FATHER □MOTHER

IF DIFFERENT THAN PATIENT:

NAME ____
LAST *FIRST* *MI*

BIRTH DATE __________________________ □MARRIED □SINGLE □MINOR □MALE □FEMALE
MONTH *DAY* *YEAR*

SOCIAL SECURITY #_________________________________

Consent for Services

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost 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 service performed without prior financial arrangements, must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will paid by an insurance company.

WE REQUIRE 24 HOUR NOTICE TO CANCEL APPOINTMENTS.

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.

X ____ Date: ________________________

Relationship to Patient: ________________________________

MEDICAL HISTORY

Do you now have or have ever had any of the following? Please check all appropriate boxes.

□AIDS	□Head Injuries	□Shortness of Breath
□Alzheimer's Disease	□Heart Disease	□Sickle Cell Anemia
□Anemia	□Heart Lesion	□Sinus Problems
□Arthritis	□Heart Murmur	□Stroke
□Artificial Heart Valve	□Heart Trouble	□Swelling of Feet-Ankles-Hands
□Artificial Joints	□Heart Surgery	□Thyroid Disease
□Asthma	□Hemophilia	□Stomach Problems
□Blood Disease	□Herpes	□Tobacco Products
□Blood Thinner	□Hepatitis A / B / C	□Tumors
□Blood Transfusion	□High Blood Pressure	□Transplants
□Bruise easily	□Low Blood Pressure	□Recent Weight Loss
□Cancer	□History of HPV	□Rheumatism
□Chemo-Radiation Therapy	□Hypoglycemia	□Venereal Disease
□Chest Pain	□Kidney Disease	□Rheumatic Fever
□Cold Sores – Fever Blister	□Liver Disease	□Tuberculosis
□Cortisone Medicine	□Lung Disease	□Ulcers
□Diabetes	□Jaundice	□Scarlet Fever
□Dizziness	□Mental Disorders	□Pacemaker
□Drug Addiction	□Mitral Valve Prolapse	□Are you pregnant Due Date _______________
□Emphysema	□Have you ever taken Phen-Phen / Redux	□Pain of Jaw Joint
□Epilepsy-Seizures	□Fainting	□Nervous Disorders
□Excessive Thirst		

ALLERGIES

□Aspirin	□Erythromycin	□Penicillin
□Clindamycin	□Ibuprofen	□Tetracycline
□Codeine	□Jewelry	□Tree Nuts
□Dental Anesthetics	□Latex	
□Epinephrine	□Metals	

Other Allergies: ____

____

Note to women: *Antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.*

Please list current medications you are taking: Including ASPIRIN and all OTC medications:

____

____

____

____

- Have you ever taken pre-medication prior to dental treatment? □ Yes □No
- Have you ever had any complications following dental treatment? □ 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 #: ____________________

- Do you have any health problems that need further clarification? □ Yes □No

If yes, please explain: ____

In case of an emergency, whom shall we call? **Name:** ___________________________________

Relationship: _____________________________

Phone Numbers: ___________________________

- *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, or if my medications change, I will inform the doctors at the next appointment without fail.*

X ____ Date: ___________________

Signature of Parent or Guardian