I acknowledge that I have received a copy of the Dental Materials Fact Sheet dated October 17, 2001 and notice of patient privacy.

_____
(patient signature) (date)

PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Patients Name _____ (LAST / FIRST / INITIAL) **Age** _____ **Spouse's Name** _____

If patient is a minor, give parent's or guardian's name: _____ **Relationship** _____

Residence Address _____ (STREET / CITY / ZIP)

☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Cell Phone No. _____ **Soc. Sec. No.** _____ **Res. Phone** _____

E-mail _____ **Patient's Birthdate** _____

Employed by _____ **Occupation** _____

Business Address _____ **Bus. Phone** _____ EXT.

Spouse Employed by _____ **Occupation** _____

Business Address _____ **Bus. Phone** _____ EXT.

Name of nearest relative not living with you: _____ **Relationship** _____

Complete Address _____ **Res. Phone** _____

Name of Physician _____ **Address** _____ (STREET / CITY / TELEPHONE)

Date of last visit _____

Former Dentist _____ **Address** _____ (STREET / CITY / TELEPHONE)

Date of last visit _____ **Date of your last dental xrays** _____

Purpose of today's appointment _____

Whom may we thank for referring you? _____

FINANCIAL and INSURANCE INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT:

Name _____

Address _____

City _____ **Zip** _____

☐ **Cash on day of treatment**

☐ **VISA** ☐ **American Express** ☐ **Discover** ☐ **Mastercard**

Card No. _____

☐ **Dental Insurance** _____ (Name of Co.)

Address _____

City _____ **Zip** _____

Insurance Group No. _____

Employer _____

Name of Insured _____

Soc. Sec. No. of Insured _____

TERMS & CONDITIONS

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 service performed without prior 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 patient's insurance forms to assist in making collections from insurance companies and will credit 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.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, 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 billed unless objected to, by me, in writing, within the time for payment thereof. Additionally, I 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 attorney fees if suit be instituted hereunder.

I grant my permission to you, or your assigns, 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 agree to their content:

Signed: _____ **Date:** _____

PLEASE COMPLETE BOTH SIDES!

HEALTH HISTORY

Place a mark on "Yes" to indicate if you have had any of the following:

- AIDS ☐ Yes
- Alcohol Use ☐ Yes
- Anemia ☐ Yes
- Arthritis, Rheumatism ☐ Yes
- Artificial Heart Valves ☐ Yes
- Artificial Joints ☐ Yes
- Asthma ☐ Yes
- Back Problems ☐ Yes
- Bleeding abnormally, with extractions or surgery ☐ Yes
- Blood Disease ☐ Yes
- Cancer ☐ Yes
- Chemical Dependency ☐ Yes
- Chemotherapy ☐ Yes
- Circulatory Problems ☐ Yes
- Congenital Heart Lesions ☐ Yes
- Cortisone Treatments ☐ Yes
- Cough, persistent or bloody ☐ Yes
- Diabetes ☐ Yes
- Do you wear contact lenses? ☐ Yes
- Eating Disorder ☐ Yes
- Emphysema ☐ Yes
- Epilepsy ☐ Yes
- Fainting or Dizziness ☐ Yes
- Glaucoma ☐ Yes
- Headaches ☐ Yes
- Heart Murmur ☐ Yes
- Heart Problems ☐ Yes
- Hepatitis ☐ Yes
  Type _____
- Herpes ☐ Yes
- High Blood Pressure ☐ Yes
- HIV Positive ☐ Yes
- Jaundice ☐ Yes
- Jaw Pain ☐ Yes
- Kidney Disease ☐ Yes
- Latex Allergy ☐ Yes
- Liver Disease ☐ Yes
- Low Blood Pressure ☐ Yes
- Mitral Valve Prolapse ☐ Yes
- Nervous Problems ☐ Yes
- Pacemaker ☐ Yes
- Psychiatric Care ☐ Yes
- Radiation Treatment ☐ Yes
- Respiratory Disease ☐ Yes
- Rheumatic Fever ☐ Yes
- Scarlet Fever ☐ Yes
- Sexually Transmitted Disease ☐ Yes
- Shortness of Breath ☐ Yes
- Sinus Trouble ☐ Yes
- Skin Rash ☐ Yes
- Sleep Apnea ☐ Yes
- Snoring ☐ Yes
- Special Diet ☐ Yes
- Stroke ☐ Yes
- Swelling of Feet or Ankles ☐ Yes
- Thyroid Problems ☐ Yes
- Tobacco Use ☐ Yes
- Tonsillitis ☐ Yes
- Tuberculosis ☐ Yes
- Tumor or growth on head or neck ☐ Yes
- Ulcer ☐ Yes
- Weight Loss, unexplained ☐ Yes
- Women:
  Are you pregnant? ☐ Yes
  Due Date _____
  Are you nursing? ☐ Yes

Do you need to premedicate with antibiotics before dental work? ☐ Yes

Are you presently taking Coumadin or any blood thinner? ☐ Yes

Have you had any surgery in the past 12 months? ☐ Yes

If yes, what/when? _____

Other _____

List medications you are currently taking:	Allergies Food/Medication

DATE	PATIENT'S/PARENT'S SIGNATURE P/BP	DOCTOR'S SIGNATURE

FOR OFFICE USE ONLY UPDATES

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Is patient taking any new medications? ☐ Yes ☐ No If so, what _____

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____