# PATIENT INFORMATION

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

Patients Name ______________________ Age ________ Spouse's Name ______________
LAST FIRST INITIAL

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 ______________________

I have reviewed and received a copy (if requested) of the Dental Materials Fact Sheet and the HIPPA Compliance Standard.

______________________
(patient signature) (date)

## 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:

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

Other ______________________________

**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? ______________________________

| 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: ____________