

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Fax: \_\_\_\_\_ Mobil/Cell \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

## Referral Information

To whom may we give credit for referring you to our practice?  Another patient, friend  Another Doctor  
 Dental Office  School  Work  Other \_\_\_\_\_

**Required:** Name of person or office referring you to our practice: \_\_\_\_\_

## Cosmetic Information

How do you feel about the appearance of your teeth? \_\_\_\_\_

Is there anything about your smile that you do not like? \_\_\_\_\_

Are you interested in knowing the options available for a more beautiful smile? \_\_\_\_\_

Are all of your teeth in alignment (straight)? \_\_\_\_\_

Do you have any missing teeth? \_\_\_\_\_ Are any chipped? \_\_\_\_\_

Is your bite comfortable when chewing, biting? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_

Do you have any old fillings or dental treatment that you are unhappy with? \_\_\_\_\_

What would you like to change the most about the appearance of your teeth? \_\_\_\_\_

Is there anything else that you would like us to know? \_\_\_\_\_

## Health Information

*For your safety, we need to know a little more about your health history.*

Previous Dentist: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

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

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS                      | <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Kidney Disease                 | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Allergies _____           | <input type="checkbox"/> Emphysema                        | <input type="checkbox"/> Latex Sensitivity              | <input type="checkbox"/> Thyroid Problems             |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Epilepsy                         | <input type="checkbox"/> Liver Disease                  | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Excessive Bleeding               | <input type="checkbox"/> Mental Disorders               | <input type="checkbox"/> Tumors                       |
| <input type="checkbox"/> Artificial Joints         | <input type="checkbox"/> Fainting                         | <input type="checkbox"/> Mitral Valve Prolapse          | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Glaucoma                         | <input type="checkbox"/> Nervous Disorders              | <input type="checkbox"/> Venereal Disease             |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Growths                          | <input type="checkbox"/> Pacemaker                      | <input type="checkbox"/> Codeine Allergy              |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Hay Fever                        | <input type="checkbox"/> Psychiatric/Psychological Care | <input type="checkbox"/> Penicillin Allergy           |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> H. I. V. Positive                | <input type="checkbox"/> <b>Pregnancy</b>               | <input type="checkbox"/> Allergic/Adverse Reaction To |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Head Injuries                    | Due date: _____   | Medication or Any Substance,                          |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart (Attack, Disease, Surgery) | <input type="checkbox"/> Radiation Treatment            | Please specify:                                       |
| <input type="checkbox"/> Contact Lenses            | <input type="checkbox"/> Heart Murmur                     | <input type="checkbox"/> Respiratory Problems           | _____   |
| <input type="checkbox"/> Cortisone Medication      | <input type="checkbox"/> Hemophilia                       | <input type="checkbox"/> Rheumatic Fever                | _____   |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hepatitis                        | <input type="checkbox"/> Rheumatism                     | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Diet (Special/Restricted) | <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Sinus Problems                 |   |
|  | <input type="checkbox"/> Jaundice                         | <input type="checkbox"/> Smoke/Chew Tobacco             |   |
|  |   | <input type="checkbox"/> Stomach Problems               |   |

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain:
- 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: \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain:
- Are you taking any medications? Please list \_\_\_\_\_

**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 doctor at the next appointment without fail.**

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

\_\_\_\_\_  
Signature of Doctor Date: \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_

Male  Female  Married  Single  Child  Other \_\_\_\_\_

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

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

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

City State Zip Code

## Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

## Insurance Information

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 Telephone: \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment 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 patient's 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.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) 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 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 attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

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.**

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

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
*Signature of guarantor of payment/responsible party*