## Patient Information

Patient Name: ________________________________________ Date____________

Male ☐ Female ☐ Other family members seen here: ____________________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: _____ (Cell): ______________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ________________________________________________
Street Apartment #

________________________________________________
City State Zip Code

## Health Information

Date of Last Dental Visit: ____________ Reason for this visit: ______________________

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

☐ AIDS
☐ Allergies
__________
__________
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease/Surgery
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke

☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ ______________
☐ ______________

- 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:
- List all current medications:________________________________________
________________________________________________
________________________________________________
________________________________________________

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.

________________________________________ Date: ______________
Signature of patient, parent or guardian

# Responsible Party Information

Name: ______________________________________________________________
☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ____________________

Social Security #: ________________ Birth Date: ______________Drivers 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 Phone

## Insurance Information

**Primary**

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 Address: ___________________________________________

___________________________________________

**Secondary**

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 Address: ___________________________________________

___________________________________________

### Consent for Services

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 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 patients 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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for 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 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 assignee, to telephone me at home or at my work to discuss matters related to this form. I affirm this information is correct and authorize dental treatment.

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