		Pati	ent Informatio	n				
Patient Name:	tient Name: Date:		Date:					
Address:	Last	First	MI	Preferred N				
/ tauress	Street				Apartment #			
	City		State		Zip Code			
Employer:				Occupatio	on:			
Family Status:	Family Status: ☐ Married ☐ Divorced ☐ Single ☐ Child ☐ Other:							
Social Security #:		Birth D	Birth Date:		Gender: □ Male □ Female			
Phone: Home		Work		ext Cell:				
Other:	Other: Which number would you like us to use for appointment reminders?							
Email Address:								
I agree to receive emails from the practice ☐ Yes ☐ No								
Spouse, Parent, or Responsible Party Information  The following is for:   Spouse Patient's Parent/Guardian Person Responsible for Payment  Name:   Employer:								
					_ Gender: ☐ Male ☐ Female			
					Cell:			
Address:								
		Insura	ance Informat	tion				
Name:			Is	subscriber a p	atient? 🗆 Yes 🗀 No			
Subscriber Birth D	Oate:	Social Security #	:		_Group#			
Subscriber's Addr	ess:							
Subscriber's Empl	loyer/Address:							
Patient Relationsh	nip to Subscriber:	☐ Self ☐ Spo	ouse $\square$ Child	☐ Other				
Insurance Co Nan	ne		Insura	nce Co Phone				
Insurance Co Address								
		Consent for S	Services (Read	d Carefully)				
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 the insurance companies and will credit any such collections to the patients 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 1/2 % per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.							
I understand that the fee estimate listed for this dental care can only be extended for a period of 30 days from the date of the patient examination.  I grant my permission to you or your assignee, to telephone me at home or my work or cell to discuss matters related to this form.  I have read the above conditions of treatment and payment and agree to their content.								
Signature of Patient, P	arent, or Guardian	Date:		Relationsh	ip to Patient			
Signture of Guarnator	of Payment/Responsib			Relationsh	ip to Patient			
How did you hear about our practice?  ☐ Friend, relative, neighbor, etc. ☐ Another dentist ☐ Post Card ☐ Mailbox Flyer ☐ Internet ☐ Sign/Drive-by  So we may thank them, please provide name of person or dentist who referred you:								

MEDICAL HISTORY	Patient Name:	Date:		
Please check all of the medica	I conditions/situations that apply to y	ou.		
<ul> <li>☐ Heart Surgery</li> <li>☐ Heart Disease</li> <li>☐ Heart Attack</li> <li>☐ Chest Pain</li> <li>☐ Congenital Heart Disease</li> <li>☐ Heart Murmur</li> <li>☐ High Blood Pressure</li> <li>☐ Mitral Valve Prolapse</li> <li>☐ Artificial Heart Valve</li> <li>☐ Heart Stent/Shunt</li> <li>☐ Heart Pacemaker</li> <li>☐ Sleep Apnea</li> <li>☐ Rheumatic Fever</li> <li>☐ Arthritis/Rheumatism</li> </ul>	<ul><li>☐ Stroke</li><li>☐ High Cholesterol</li><li>☐ Kidney Trouble</li><li>☐ Kidney Stent/Shunt</li></ul>	☐ Tuberculosis ☐ Asthma ☐ Hay Fever ☐ Sinus Trouble ☐ Allergies or Hives ☐ Latex Sensitivity ☐ Liver Disease	□ AIDS □ Blood Transfusion □ Blood Thinners □ Hemophilia □ Sickle Cell Disease □ Neurological Disorder □ Epilepsy or Seizures □ Fainting or Dizzy Spells □ Nervous/Anxious □ Psychiatric Care □ TMJ Disorder □ Smoke/Chew/Vape Tobacco □ Jaw/Ear Pain	
Do you have any artificial join	ts? □ No □ Yes → Please tell us whi	ch joint(s) and what year you go	ot it/them	
Name of Physician  Are you taking any medication	nysician? □ No □ Yes → Please explan, drugs, or pills now? □ No □ Yes	⇒Please list		
What is the reason for your v	sit today?			
Date of Last Cleaning?		Date of Last Full Set of X-Rays?	?	
Have you ever been diagnose	d with periodontal "gum" disease? □	l No □ Yes → Date of treat	ment	
What is your goal in seeking o ☐ Prevent problems	ental care? Please check all that appl	☐ Fix cosmetic problems	☐ Resolve pain only	
	□ No □ Yes → Months A control pills? □ No □ Yes	re you nursing? ☐ No ☐ Yes		
	Doct	or Signature:	<u>-</u>	
all questions to the best of my provider or agency who may re hereby authorize the doctor of appropriate by the doctor to re diagnosis, I authorize the doctor as required to provide proper	tion above is necessary to provide me knowledge. Should further informati elease such information to you. I will or designated staff to take x-rays, stud- make a thorough diagnosis of for to perform all recommended treat care. I agree to the use of anesthetics mbodies certain risks; I understand the	ion be needed, you have my per notify the doctor of any change y models, photographs, and any (Patient ment mutual agreed upon by m s, sedatives, and other medication	rmission to ask the respective care in my health or medication. I other diagnostic aids deemed Name)'s dental needs. Upon such he and to employ such assistance on necessary. I fully understand	
Patient	<u>Date</u>	Witness		
Responsible Party Relationship to Patient				



## Medical Information Release Form (HIPAA Release Form)

Name:	Date of Birth:/						
	Release of Information						
	ase of information including the diagnosis, records, examination ms information. This information may be released to:						
☐ Spouse							
☐ Child(ren)							
☐ Other(s)							
☐ Information is not t	Information is not to be released to anyone.						
This <b>Release of informa</b>	tion will remain in effect until terminated by me in writing.						
	<u>Messages</u>						
Please call □ my home	□ my work □ my cell number:						
If unable to reach me:							
•	etailed message sking me to return your call						
The best time to reach me	e is (day) between (time)						
Signed:	Date:/						
Witness:	Date:/						