

Patient Information

Patient Name: _____ Date: _____

Address: _____
Last First MI Preferred Name

Street Apartment #

City State Zip Code

Employer: _____ Occupation: _____

Family Status: Married Divorced Single Child Other: _____

Social Security #: _____ Birth Date: _____ Gender: Male Female

Phone: Home _____ Work _____ ext. _____ Cell: _____

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: _____

Social Security #: _____ Birth Date: _____ Gender: Male Female

Phone: Home _____ Work _____ ext. _____ Cell: _____

Address: _____

Insurance Information

Name: _____ Is subscriber a patient? Yes No

Subscriber Birth Date: _____ Social Security #: _____ Group# _____

Subscriber's Address: _____

Subscriber's Employer/Address: _____

Patient Relationship to Subscriber: Self Spouse Child Other _____

Insurance Co Name _____ Insurance Co Phone _____

Insurance Co Address _____

Consent for Services (Read 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.

Date: _____ Relationship to Patient _____
Signature of Patient, Parent, or Guardian

Date: _____ Relationship to Patient _____
Signature of Guarantor of Payment/Responsible Party

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 medical conditions/situations that apply to you.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Kidney Stent/Shunt | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> History of Bisphosphonates? | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous/Anxious |
| <input type="checkbox"/> Heart Stent/Shunt | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Cancer | <input type="checkbox"/> HPV Diagnosis | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Smoke/Chew/Vape Tobacco |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Jaw/Ear Pain |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Tumors | <input type="checkbox"/> Glaucoma | |

Do you have any artificial joints? No Yes → Please tell us which joint(s) and what year you got it/them _____Do you have or have you had any disease, condition, or problem not listed above? No Yes → Please list _____Are you under the care of a physician? No Yes → Please explain _____

Name of Physician _____

Are you taking any medication, drugs, or pills now? No Yes → Please list _____Are you aware of having an allergy (or adverse reaction) to any medication or substance? No Yes → Please list _____

What is the reason for your visit today? _____

Date of Last Cleaning? _____ Date of Last Full Set of X-Rays? _____

Have you ever been diagnosed with periodontal "gum" disease? No Yes → Date of treatment _____

What is your goal in seeking dental care? Please check all that apply

-
- Prevent problems
-
- Maintain current oral health
-
- Fix cosmetic problems
-
- Resolve pain only

WOMEN: Are you pregnant? No Yes → _____ Months Are you nursing? No YesAre you taking birth control pills? No Yes

Doctor Signature: _____

I understand that the information above is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____ (Patient Name)'s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutual agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication necessary. I fully understand that using anesthetic agents embodies certain risks; I understand that I can ask for a complete recital of any possible complications.

Patient _____ Date _____ Witness _____

Responsible Party _____ Relationship to Patient _____



Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other(s) _____

Information is not to be released to anyone.

This **Release of information** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell number: _____

If unable to reach me:

you may leave a detailed message

leave a message asking me to return your call

Other instruction: _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____