Patient Information										
Patient Name:	t Name:Date:Date:									
Address:	Last	First	MI	Preferred Name						
	Street				Apartment #					
	City		State		Zip Code					
Employer:										
		orced □ Single □ Child □ Oth								
		Birth Date:								
Phone: Cell		Please check number to be used for	or appointment re	🛛 Work minders						
Emergency Conta	act Name		_ Phone		_ Relationship					
l agree to receive	e emails from th	e practice □ Yes □ No								
Spouse, Parent, or Responsible Party Information The following is for:										
Name:			Employer:							
Social Security #:		Birth Date:	·	Gender	: 🗆 Male 🗆 Female					
Phone: Home		Work		ext Cell:						
Address:										
		Insuranc	e Informatio	ı						
Name:			Is sul	oscriber a patient? D] Yes 🗆 No					
Subscriber Birth Date: Social Security #:Group#										
Subscriber's Add	ress:									
Subscriber's Emp	loyer/Address:									
Patient Relations	hip to Subscribe	er: 🗆 Self 🗆 Spouse	e 🗆 Child 🗆] Other						
Insurance Co Nar	ne		Insurance Co Phone							
Insurance Co Ado	dress									
		Consent for Serv	vices (Read C	arefully)						
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 patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.										
-	1/2 % per month (1	8% per annum) on the unpaid balanc	e may be charged	on all accounts exceeding	g 60 days, unless previously written					
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, Pa	rent, or Guardian				ıt					
Signture of Guarnator of	f Payment/Responsible									
How did you hear about our practice? Friend, relative, neighbor, etc. Another dentist Post Card Mailbox Flyer Internet So we may thank them, please provide name of person or dentist who referred you:										

MEDICAL HISTORY	Patient Name:	D	Date:					
Please check all of the medical	conditions/situations that apply to y	ou.						
 Heart Surgery Heart Disease Heart Attack Chest Pain Congenital Heart Disease Heart Murmur High Blood Pressure Mitral Valve Prolapse Artificial Heart Valve Heart Stent/Shunt Heart Pacemaker Sleep Apnea Rheumatic Fever Arthritis/Rheumatism 	 Stroke High Cholesterol Kidney Trouble Kidney Stent/Shunt Diabetes Thyroid Problems Osteoporosis ➡ History of Bisphosphonates? Emphysema Chronic Cough Cancer Radiation Therapy Chemotherapy Tumors s? □ No □ Yes ➡ Please tell us white 	 Headaches Venereal Disease HPV Diagnosis Cold Sores/Fever Blisters HIV Positive Glaucoma 	 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 or have you had a	any disease, condition, or problem no	t listed above? □ No □ Yes•	→ Please list					
Are you under the care of a ph	ıysician? □ No □ Yes ➡ Please expla	in						
Name of Physician								
	, drugs, or pills now? □ No □ Yes ergy (or adverse reaction) to any med		□ Yes ➡ Please list					
What is the reason for your vis	sit today?							
Date of Last Cleaning?		Date of Last Full Set of X-Rays	?					
Have you ever been diagnosed	l with periodontal "gum" disease?	INo □Yes ➡ Date of trea	tment					
What is your goal in seeking d	ental care? Please check all that apply		□ Resolve pain only					
	□ No □ Yes ➡ Months A control pills? □ No □ Yes	re you nursing? 🗆 No 🛛 Yes						
	Doct	or Signature:						
all questions to the best of my provider or agency who may re hereby authorize the doctor or appropriate by the doctor to n diagnosis, I authorize the doct as required to provide proper	ion above is necessary to provide me knowledge. Should further informati elease such information to you. I will r designated staff to take x-rays, study hake a thorough diagnosis of or to perform all recommended treat care. I agree to the use of anesthetics mbodies certain risks; I understand th	with dental care in a safe and on be needed, you have my pe notify the doctor of any chang y models, photographs, and an (Patien ment mutual agreed upon by r s, sedatives, and other medicat	efficient manner. I have answered ermission to ask the respective care e in my health or medication. I y other diagnostic aids deemed t Name)'s dental needs. Upon such me and to employ such assistance ion necessary. I fully understand					
Patient	Date	Witness						
Responsible Party	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 num	ber:					
If unable to reach me:									
 you may leave a detailed message leave a message asking me to return your call Other instruction: 									
The best tim	e to reach me is ((day)	ł	between (ti	me)				
Signed:				Date:	/	/			
Witness:				Date:	/	_/			