Patient Information

Patient Name: _____ Nickname: _____
Last First MI

Birth Date: _____ Social Security #: _____ **(Circle)** Single Married Child Other

Mailing Address:_____

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

Responsible Party (if other than self)

Name: _____ Relationship to Patient: _____

Birth Date: _____ Social Security #: _____ **(Circle)** Single Married Other

Mailing Address: _____

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

Health Information

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

- ☐ AIDS
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chew on One Side
- ☐ Clench or Grind Teeth
- ☐ Diabetes
- ☐ Difficult Extractions
- ☐ Donor Organs
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injuries
- ☐ Heart Disease/Surgery
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Migraines
- ☐ Novocaine Allergy or Side Effects
- ☐ Pacemaker
- ☐ Pregnancy Due Date _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sensitive Teeth
- ☐ Sinus Problems
- ☐ Stomach or Intestinal Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Venereal Disease

Please list any medication allergies: _____

Please list any major operations: _____

Please list any complications from dental treatment: _____

Name of Physician: _____ **Phone:** _____

Please list 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 you at the next appointment.

_____ _____
Signature of Patient (or Parent or Guardian if Minor) Date

Insurance Information

Dental Insurance: _____ **Phone:** _____

Insurance Claims Address: _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____ Phone: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

I authorize treatment by the doctor and supporting staff members.

I understand there may be a minimum charge of $35.00 for broken appointments without 24 hours notice.

I authorize assignment of benefits where applicable. If payment has not been received from the insurance company within 4 weeks from the date of service, I will accept full responsibility for payment in full within 30 days of notification.

All emergency dental services must be paid for at time of service.

Patients, or Responsible Parties, are responsible for all fees incurred regardless of dental insurance. We do participate with a limited number of insurance companies. All copayments and deductibles are due at time of service. If you have insurance that we do not participate with, all payments are due at time of service. We will, as a courtesy, file your insurance claim.

A service charge of 1½% per month (18% per annum), minimum of $5.00, on the unpaid balance will be charged on all accounts exceeding 60 days.

I accept full responsibility for any legal or collection agency fees (currently 40%) should my account become delinquent.

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 received a copy of this office's Notice of Privacy Practices.

I have read the above conditions of treatment and payment and agree to their content.

_____

Patient or Responsible Party **(Print)** Relationship to Patient

_____

Patient or Responsible Party **(Signature)** Date