PATIENT INFORMATION

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security No.: _____ Birth Date: _____ Gender: _____ Family Status: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

In case of emergency, notify: _____ Phone: _____

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

EMPLOYMENT INFORMATION

The following information is for: ☐ The patient ☐ The person responsible for payment Insurance: _____Yes _____ No

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

HEALTH HISTORY

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
☐ Heart Murmur
☐ Mitral Valve Prolaspe (MVP)
☐ 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: _____

Allergies to Medications: _____

Are you taking any of the following?

A. Antibiotics or sulfa drugs? ___ Yes ___ No
B. Anticoagulants (blood thinners): ___ Yes ___ No
C. Medicine for high blood pressure: ___ Yes ___ No
D. Cortisone (steroids): ___ Yes ___ No
E. Tranquilizers: ___ Yes ___ No
F. Antihistamines: ___ Yes ___ No
G. Aspirin: ___ Yes ___ No
H. Insulin, tolbutamide(orinase): ___ Yes ___ No
I. Digitalls or drugs for heart trouble: ___ Yes ___ No
J. Nitroglycerin: ___ Yes ___ No
K. Coumadin: ___ Yes ___ No
L. Oral contraceptive or other hormonal therapy: ___ Yes ___ No

1. Are you in good health? ___ Yes ___ No
2. Has there been any change in your general health within the past year? ___ Yes ___ No
3. Are you now under the care of a physician? ___ Yes ___ No
   If yes, name of physician: _____
4. Have you had any serious illness or operation? ___ Yes ___ No
   If so, what was the illness or operation?
5. Have you been hospitalized or had a serious illness within the past five (5) years? ___ Yes ___ No
   If so, what was the problem? _____
6. Have you had any serious trouble associated with any previous dental treatment? ___ Yes ___ No
   If so, explain: _____
7. Do you have any disease, condition, or problem not listed above that you think I should know about? ___ Yes ___ No
   If so, explain: _____

HEALTH INFORMATION (CONTINUED)

List all Drugs/Medications/Herbal Supplements you are taking and conditions being treated:

MEDICINES	CONDITIONS
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Pharmacy Name: _____ **Phone:** _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

☐ Another patient, friend ☐ Newspaper ☐ Dental Office ☐ Yellow Pages

☐ Another patient, relative ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice: _____

CONSENT FOR SERVICES

PAYMENT

All dental services must be paid by check, cash, credit card (VISA, MASTERCARD, DISCOVER) at the time services are performed. There is a **$30.00** fee for returned checks for non-sufficient funds.

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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

TREATMENT PLAN COST ESTIMATES

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

TELEPHONE COMMUNICATION

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.

CANCELLATION FEE

There is a **$30.00** charge for any appointment not cancelled 24 hours in advance.

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

_____ _____

Signature of patient, parent, or guarantor of payment/responsible party **Date**