Patient Information

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

Address: _____
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) _____ (Fax) _____

(other) _____ Which number would you like us to use to for appointment remind ers? _____

E-mail Address: _____

Spouse, Parent or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the patient's parent/guardian ☐ the person responsible for payment ☐ Male ☐ Female

Name: _____ Employer: _____

Social Security #: _____ Birth Date: _____

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

Address: _____

Insurance Information

Name: _____ Is the subscriber a patient? Yes…….No
Subscriber's Birth Date: _____ SS #: _____ Group #: _____
Subscriber's Address: _____
Subscriber's Employer/Address: _____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Co. Name/Phone/Address (Home): _____
_____

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.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Whom may we thank for referring you to our practice? (Circle One)

Another patient, friend or relative ….Mailing …. Dental office …. Insurance …. Work …. Internet …… Sign/ Drive by
Other: _____

Name of person or office referring you to our practice (So we can send them a "thank you"): _____

MEDICAL HISTORY

PATIENT NAME: _____ Date: _____

Heart (Surgery, Disease, Attack)….	Yes	No	Emphysema……..	Yes	No	Venereal Disease…….	Yes	No
Chest Pain……..	Yes	No	Chronic Cough……..	Yes	No	H.I.V. Positive……	Yes	No
Congenital Heart Disease…..	Yes	No	Cancer……...	Yes	No	A.I.D.S……	Yes	No
Heart Murmur……	Yes	No	Tuberculosis……..	Yes	No	Blood Transfusion……...	Yes	No
High Blood Pressure……..	Yes	No	Asthma……..	Yes	No	Hemophilia……..	Yes	No
Mitral Valve Prolapse……	Yes	No	Hay Fever……..	Yes	No	Sickle Cell Disease…….	Yes	No
Artificial Heart Valve…….	Yes	No	Sinus Trouble……	Yes	No	Neurological Disorders……...	Yes	No
Heart Stint/Shunt……	Yes	No	Allergies or Hives…….	Yes	No	Epilepsy or Seizures……...	Yes	No
Heart Pacemaker……	Yes	No	Latex Sensitivity……...	Yes	No	Fainting or Dizzy Spells……..	Yes	No
Rheumatic Fever……	Yes	No	Radiation Therapy……	Yes	No	Nervous/Anxious……	Yes	No
Arthritis/Rheumatism…….	Yes	No	Chemotherapy……...	Yes	No	Psychiatric Care……..	Yes	No
Stroke…….	Yes	No	Tumors……..	Yes	No	Cold Sores……...	Yes	No
Artificial Joints……...	Yes	No	Hepatitis A ……..……	Yes	No	Fever Blisters……..	Yes	No
Kidney Trouble……..	Yes	No	Hepatitis B ……..……	Yes	No	Allergy to Jewelry/Metal……	Yes	No
Diabetes……..	Yes	No	Hepatitis C ……...	Yes	No	TMJ Disorder……..	Yes	No
Thyroid Problems……...	Yes	No	Liver Disease……..	Yes	No	Smoke/Chew Tobacco……	Yes	No
Osteoporosis……...	Yes	No	Headaches……	Yes	No	Jaw/Ear Pain……...	Yes	No

What is the reason for your visit today? _____

Date of your last Cleaning? _____ Last Full Mouth Set of X -rays? _____

Do you have any health problems that need further clarification? …….. Yes No
If yes, please explain _____

Do you have or have you had any disease, condition or problem not listed? ……. Yes No
If yes, please list _____

Are you under the care of a physician? …… Yes No
If yes, please explain _____
Name of physician _____

Are you taking any medication, drugs or pills now? ……. Yes No
If yes, please list: _____
_____

Are you aware of having an allergy (or adverse reaction) to any medication or substance? …….. Yes No
If yes, please list: _____

Have you ever been diagnosed with Periodontal "Gum" disease? ……. Yes No
If yes, date of treatment_____

Women : Are you: Pregnant ? No...Yes ___Months Nursing ? No….Yes Taking Birth Control Pills ? No…. Yes

Doctor Signature: _____

I understand the above information 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 health 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 doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (Name of Patient) _____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually 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 _____

Parent or 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 _____

[ ] 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

[ ] please leave a message asking me to return your call

[ ] _____

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

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____