Patient Information										
Patient Name:					Date:					
Address:	Last	First	MI	Preferred Nam						
	Street				Apartment #					
	City		State		Zip Code					
Employer:				_ Occupation:						
Family Status: 🛛	Married Divorced D	Single 🗆 Child 🗆 Oth	ner:							
Social Security #:		Birth Date:	:		ender: 🗆 Male 🗆 Female					
Phone: Home		Work		_ext	Cell:					
Other:	Which nu	nber would you like	us to use for a	appointment re	eminders?					
Email Address:										
I agree to receive emails from the practice 🛛 Yes 🗆 No										
Spouse, Parent, or Responsible Party Information										
	or: 🗆 Spouse 🗆 Pat									
Social Security #:		Birth Date:	:		Gender: 🗆 Male 🗆 Female					
Phone: Home		Work		_ext	Cell:					
			e Informatio							
Name:			ls su	bscriber a pati	ent? 🗆 Yes 🗆 No					
				G	roup#					
Subscriber's Emp										
Patient Relations	hip to Subscriber:	□ Self □ Spouse	e 🗆 Child 🛛	Other						
Insurance Co Nan	ne		Insuranc	e Co Phone						
Insurance Co Add	lress									
		Consent for Serv	vices (Read C	arefully)						
		cial arrangements must b	e made in advance	e. The practice de	pends upon reimbursement from the patients for					
	med without previous financial		-		e treatment. All emergency dental services, or any 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 compan A service charge of 1 financial arrangement	1/2 % per month (18% per annu	ım) on the unpaid balanc	e may be charged	on all accounts ex	cceeding 60 days, unless previously written					
-		al care can only be exten	ded for a period o	of 30 days from th	e date of the patient examination.					
	to you or your assignee, to tele		-	iscuss matters rela	ated to this form.					
i nave redu trie above	conditions of treatment and p			Relationshin to	o Patient					
Signature of Patient, F	Parent, or Guardian									
Signture of Guarnator	r of Payment/Responsible Party			Relationship to	o Patient					
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:	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	esponsible 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	ıber:				
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	between (time)						
Signed:				Date:	/	_/		
Witness:				Date:	/	_/		