Patient Information

Patient Name:_____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ E-Mail: _____

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

In case of Emergency, contact: Name _____ Phone _____ Relation _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Previous Dentist: _____

Date of Last Dental Visit: _____ Date of Last x-rays: _____

Reason for this visit: _____

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

☐ AIDS	☐ Glaucoma	☐ Lung Disease	☐ Tobacco Usage
☐ Allergies _____	☐ Growths	☐ Mental Disorders	☐ Tuberculosis
_____	☐ Hay Fever	☐ Mitral Valve Prolapse (MVP)	☐ Tumors
☐ Anemia	☐ Head Injuries	☐ Nervous Disorders	☐ Ulcers
☐ Arthritis	☐ Heart Attack	☐ Pacemaker	☐ Venereal Disease
☐ Artificial Joints	☐ Heart Defect	☐ Pregnancy	☐ Antibiotics Allergy
☐ Asthma	☐ Heart Disease	Due: _____	☐ Codeine Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Prescribed Weight Loss Med	☐ Latex Allergy
☐ Cancer	☐ Hepatitis	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Chest Pain	☐ High Blood Pressure	☐ Respiratory Problems	☐ Other Anesthetic Allergy
☐ Diabetes	☐ HIV	☐ Rheumatic Fever	
☐ Dizziness	☐ Jaundice	☐ Rheumatism	OTHER:
☐ Epilepsy	☐ Joint Replacement	☐ Sinus Problems	☐ _____
☐ Excessive Bleeding	☐ Kidney Disease	☐ Stomach Problems	☐ _____
☐ Fainting	☐ Liver Disease	☐ Stroke	☐ _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

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

Are you taking any medications? Please List: _____

_____

What is your primary source of water? ☐ Well ☐ County
Do you pre-medicate for dental appointments? ☐ Yes ☐ No If so, why _____

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 the doctor at the next appointment without fail.

_____ Date: _____

Cosmetic Information

Is there anything about your smile that you do not like? _____

Are you interested in knowing the options available for a more beautiful smile? _____

Do you like the appearance of your teeth? _____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

What would you like to change the most about the appearance of your teeth? _____

_____

Is there anything else that you would like us to know? _____

Referral Information

Whom may we thank for referring you to our practice? □ Another patient, friend □ Another Doctor

□ Radio ad □ Elan Magazine □ School □ Work □ Other _____

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

Spouse or Responsible Party Information

The following is for: □ the patient's spouse □ the person responsible for payment

Name: _____

□ Male □ Female □ Married □ Single □ Child □ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Name of Insured: _____ Is insured a patient? □ Yes □ No

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

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

Insurance Plan Name and Telephone: _____

Assignment of Benefits
I authorize payment of dental benefits to the named provider for professional services rendered.

Name _____ Date _____

Assignment of Benefits
I authorize the release of any dental information necessary to process claims

Name _____ Date _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

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 patient's 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 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

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

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