

Patient Information			
Patient Name: _____			Date: _____
Last	First	MI	(Preferred Name) Gender: (M/F) _____
			Marital Status: _____
Social Security #: _____		Birth date: _____	E-Mail Address: _____
Phone (Home): _____		(Work): _____	Ext. _____ Drivers Licenses: _____
Fax: _____		Pager: _____ Name of Person referring you: _____	
Address _____			
Street		Apartment #	
City		State	Zip Code

Health Information

Date of last dental visit: _____ Reason for this visit: _____

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

- | | | | |
|--------------------------------------------|----------------------------------------------|------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | Other: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Dizziness | | <input type="checkbox"/> Stomach Problems | |

❖ 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 2 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: _____

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 doctors at the next appointment without fail.

Date: _____

 Signature of patient, parent or guardian

Medical Updates

I have read my Medical History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient's Signature	Reviewed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Responsible Party Information

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

Name: _____ Drivers Licenses: _____

Social Security # _____ Birth Date: _____

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

Address: _____

City

State

Zip Code

Male

Female

Married

Single

Child

Other _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____ Phone: _____

Street

City

State

Zip Code

Insurance Information

Primary

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

Last

First

MI

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

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

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

Insurance Plan Name and Address _____

Secondary

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

Last

First

MI

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

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

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

Insurance Plan Name and Address _____

Consent for Services

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and 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 patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

I authorize use of this form on all my insurance submissions and to act as my agent in helping me obtain payment from my insurance carrier. I authorize direct payment to my doctor and authorize a copy of this to be used in place of the original.

Inconsideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore 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.

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.

Signature of patient, parent, or guardian

Date _____

Relationship to Patient _____

Signature of guarantor of payment/responsible party

Date _____

Relationship to Patient _____