PATIENT INFORMATION

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

Social Security #: Birth Date:

Primary Contact #: _____ (Secondary/Work): _____ Email:_____

Address:
Street Apartment #

City State Zip Code

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 Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding w/ extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Headaches / Injuries
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained

ALLERGIES

☐ Aspirin ☐ Barbiturates
☐ Codine ☐ Iodine
☐ Latex ☐ Penicillin
☐ Sulfa
☐ Other _____

· Women: Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No

Dental Health History

Reason for today's visit _____

Former Dentist _____
City/State
_____

Date of last dental visit _____

Date of last dental x-rays_____
_____

Place a mark on **"Yes**" or **"No"** to indicate if you have any of the following:

Bad breath ☐ Yes ☐ No
Bleeding gums ☐ Yes ☐ No
Blisters on lips or mouth ☐ Yes ☐ No
Burning sensation of tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No
Cigarette, pipe, or cigar smoking ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Dry Mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between teeth ☐ Yes ☐ No
Foreign objects ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Gums Swollen or tender ☐ Yes ☐ No
Jaw Pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? _____

How often do you Brush? _____

	Mouth pain, brushing ☐ Yes ☐ No	

Medications: (Please list all medications you are currently taking, over-the-counter and Rx)

Pharmacy Name and Phone:

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

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Google ☐ Zoc Doc ☐ Magazine (Name) _____ ☐ Unknown

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

Date of Birth:

Insurance Information

Name of Insurance Carrier: _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

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 Full 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 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 **30 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 six 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 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.

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