Patient Name: _____ Preferred _____
First Middle Last Name

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Other Phone:_____

Patient Date of Birth:_____ Patient Social Security #:_____ Status: M S W D

Patients Employer _____

E-Mail Address _____ Do You Prefer Contact By: Email Text Phone: Cell or Home
(Please circle preference/s)

RESPONSIBLE PARTY / INSURANCE INFORMATION

Name of Parent / Subscriber:_____

Date of Birth:_____ Social Security #:_____ WK phone:_____

Employer:_____ Insurance Name:_____

Group #:_____ Phone #:_____Other Insurance: Y N

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 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 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.

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 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

Reason for Visit :_____Date of last Dental Visit:_____

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

- ☐ AIDS /HIV
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy/ due date_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other: _____ _____

Have you ever had any complications following dental treatment? ☐ yes ☐ no

If yes, please explain:_____

Have you ever been admitted to a hospital or needed emergency care during the past two yrs?

If yes, please explain:_____

Are you now under the care of a physician? ☐ Yes ☐ No **Do you take any medications?** ☐ Yes ☐ No

If yes, please explain:_____

Name of Physician:_____Phone #:_____

Do you have any health problems that need further clarifications? ☐ Yes ☐ No

If yes, please list:_____

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? ☐ name of patient, friend, relative _____

☐ Yellow Pages ☐ Internet ☐ Work ☐ Brochure ☐ Insurance ☐ Location ☐ Other _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been offered a copy of this office's Notice of Privacy Practices.
(Please Print Name)

Signature Date

Doctor Signature Date