



Chart #: _____
FOR OFFICE USE ONLY

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext. _____ Best time to call: _____

Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S

Address: _____ Apartment # _____

City _____ State _____ Zip Code _____

Email Address: _____

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"/> Heart Murmur | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Heart Valve Surgery | Due Date: _____ | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growths | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack Date _____ | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke | |
| | | | <input type="checkbox"/> Pacemaker | |

• Are you allergic to any foods or drugs? Yes No
If yes please explain: _____

• Are you currently taking any medications or supplements, prescription or over the counter? Yes No
If yes please explain: _____

• 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: _____

To the best of my knowledge, all 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.

Signature of patient, parent or guardian _____ Date: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another Patient, Friend Another Patient, Relative
 Dental Office Yellow Pages Newspaper 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: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext. _____ Best time to call: _____
Address: _____ Apartment # _____
City _____ State _____ Zip Code _____

EMPLOYMENT INFORMATION

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

Employer Name: _____ Occupation: _____
Address: _____ City _____ State _____ Zip Code _____

INSURANCE INFORMATION

PRIMARY

Name: _____ 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
Insured's Employer Name: _____
Address: _____
Street City State Zip
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

SECONDARY

Name: _____ 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
Insured's Employer Name: _____
Address: _____
Street City State Zip
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

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 cost 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 any insurance company.

A service charge of 1-1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 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, all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me 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: _____