WELCOME

Date: ____________________

Patient Information

Patient's Name: ____ ☐ M ☐ F
First MI Last

Spouse (or Guardian): ____
☐ Married ☐ Single
☐ Widowed ☐ Divorced

Home Address: ____
Street Apartment #

____
City State Zipcode

Birth Date: ____________ Drivers License #: ____________ Social Security #: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ________

Mobile Phone: ____________ Email Address: ____________

Health Information

Year of last dental visit: ________ Reason for your visit today: ____________

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

- ☐ AIDS
- ☐ Alcohol Use
- ☐ Angina / Chest Pain
- ☐ Arthritis
- ☐ **Artificial Heart Valve**
- ☐ **Artificial Joints**
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug /Alcohol Rehabilitation
- ☐ Drug Use (Illegal)
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fever Blisters / Mouth Ulcers
- ☐ Head Injuries
- ☐ Hearing Problem
- ☐ Heart Disease
- ☐ **Heart Murmur**
- ☐ Hepatitis (Type ________)
- ☐ High Blood Pressure
- ☐ HIV+
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ **Mitral Valve Prolapse**
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due date: ____________
  Are you nursing?
  ☐ Yes ☐ No
- ☐ **Radiation Treatment**
- ☐ Respiratory Problems
- ☐ **Rheumatic Fever**
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors

Do you smoke or use tobacco products?
☐ Yes ☐ No

Have you ever taken IV Bisphosphonates like Aredia or Zometa?
☐ Yes ☐ No

MEDICATIONS you are currently taking: ____

____

ALLERGIES causing swelling, rash, hives, itching or difficulty breathing:

- ☐ Advil
- ☐ Aleve
- ☐ Aspirin
- ☐ Cephalosporin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Doxycycline
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Tramadol
- ☐ Tylenol
- ☐ Other drugs:
  ____
  ____

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

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

☐ Yes ☐ No Are you now under the care of a physician? *If yes, please explain:* ______________________________
Name of Physician: ____________________ *Phone:* ____________________

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

______________________________ ____________________
Signature of patient, parent or guardian *Date*

Updated ____________ ____________ ____________ ____________

Employment Information

Occupation: ______________________ Employer Name: ______________________

Address: ______________________

Street Suite # City State Zipcode

Insurance Information

Name of Insured: ______________________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

First MI Last

Insured's Birth Date: ______________________ Insured's Social Security #: ______________________

Insured's ID#: ______________________ Group#: ______________________

Insured's Address: ______________________

Street Apt # City State Zipcode

Insured's Employer: ______________________

Employer's Address: ______________________

Street Suite # City State Zipcode

Insurance Plan Name: ______________________

Insurance Address: ______________________

Insurance Phone #: ______________________

Referral Information

How did you learn about our practice? ☐ Location ☐ Magazine ☐ Radio ☐ Website ☐ Google ☐ Facebook

☐ Other ______________________

☐ Another patient, friend ☐ Another patient, relative

Name of person referring you to our practice: ______________________

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 insurance 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 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 1½% 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 by the doctor, I agree to pay at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree to pay all costs and 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*