Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date _____:_____

Phone (Home): _____ (Work): _____ Ext:_ (Cellular): _ ___

E- mail Address: _____

Address: _____
Street Apartment #

_____ _____ _____
City State Zip Code

Medical History

(Please circle Yes or No)

Any reaction or allergy to:

Latex/Talcum Powder	Yes	No	Thyroid Disorders/ Meds	Yes	No	Psychological Treatment	Yes	No
Dental Anesthetic	Yes	No	AIDS/HIV	Yes	No	High/Low Blood Pressure	Yes	No
Aspirin	Yes	No	Kidney Disease	Yes	No	Stroke	Yes	No
Codeine	Yes	No	Hepatitis	Yes	No	Chest Pain	Yes	No
Other Narcotics	Yes	No	Liver Disease	Yes	No	HPV (Human Papilloma	Yes	No
List_____			Chemical Dependency	Yes	No	Virus)		
Antibiotics	Yes	No	Diabetes	Yes	No			
List_____			Epilepsy/Seizures	Yes	No	Stomach Problems	Yes	No
Any other allergies	Yes	No	Tuberculosis	Yes	No	Intestinal Disorder	Yes	No
List_____			Asthma	Yes	No	Tumor/Cancer/Growths	Yes	No
Emphysema	Yes	No	Radiation Treatment	Yes	No	Headaches	Yes	No
Sinus Trouble	Yes	No	Emotional Problems	Yes	No	Chemotherapy	Yes	No
Any Metals	Yes	No	Artificial Valve/Joint	Yes	No	Autoimmune Disease	Yes	No
Rheumatoid Arthritis	Yes	No	Shortness of Breath	Yes	No	Hospitalized for illness/	Yes	No
Anemia	Yes	No	Prolonged Bleeding	Yes	No	surgery? Year_____		
						Explain _____		

Are you currently:

Being treated for any illness?	Yes	No	**Taking any medication**	Yes	No	**If female are you:**		
Explain_____			List _____			Pregnant	Yes	No
Smoking	Yes	No	_____					
Using Smokeless Tobacco	Yes	No	_____			Taking Hormone Therapy	Yes	No
Taking Aspirin	Yes	No	_____					

Do you require premedication prior to dental treatment?_____

Name of Physician: _____ Phone:
_____

Authorized Signature_____ **Date**_____

Dental History

Previous Dentist_____ Last Visit_____ Reason for Leaving_____

Circle all that apply to you:

Broken Fillings	Sweet Sensitivity	Food Getting Trapped	Periodontal Disease Periodontist _____
Broken Teeth	Grinding/Clenching	Missing Teeth	Previous Orthodontic Treatment
Discolored Fillings	Biting Sensitivity	Bleeding Gums	Heavy Bleeding After Extraction
Cold Sensitivity	Cold Sores/Blisters	Dry Mouth	Dentures/Partials
Hot Sensitivity	Loose Teeth	Canker Sores	TMJ/Splint

What is your main reason for seeking dental advice today?_____

If you could change anything about your smile, what would it be?_____

Referral Information

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

☐ Dr. in Building ☐ Yellow Pages ☐ Web Site ☐ Mailer ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

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

Secondary

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

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.

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, 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

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Standard of Care

Minimum requirements of skill and knowledge must be met regarding the diagnosis and treatment of the patient. The dentist and dental hygienist must proceed as a reasonably prudent and competent team providing care. This standard of care is the manner in which a dentist and a hygienist must practice. The standard of care accepted in our practice is as follows but is not limited to:

3,4, or 6 month preventative care appointments, treatment and re-treatment of periodontal disease, full mouth series or radiographs as needed, pre-diagnostic test that aides in detection of mucosal abnormalities, fluoride treatment, airway assessment in the screening of apnea, diagnosis and treatment of oral infection.

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