Patient Name _____ Date of Birth _____

Home Address _____ Home Phone _____

City / State / Zip _____ E-mail _____

Social Security Number _____

Occupation _____ Employer _____ Phone # _____

Employer Address _____

Marital Status _____ Spouse's Name _____

Spouse's Date of Birth _____ Spouse's Social Security Number _____

Spouse's Occupation _____ Employer _____ Phone # _____

Employer Address _____

Which of these influenced your decision to see us:

☐ Referral ☐ Phone book ☐ Website ☐ Family Member Patients ☐ Newspaper ☐ Services ☐ Welcome to the area letter ☐ Radio ☐ Location

If referred, who may we thank? _____

Please list other family members we have seen: _____

In case of emergency, whom may we contact? _____ Phone # _____

If patient is under 18 or full-time student, please complete

School _____

Father's Name _____

Date of Birth _____ Social Security Number _____

Address and Phone (if different from child's) _____

Employer and Address _____ Phone # _____

Mother's Name _____

Date of Birth _____ Social Security Number _____

Address and Phone (if different from child's) _____

Employer and Address _____ Phone # _____

Insurance Information

Do you have dental insurance? _____ Primary Name of Insurance Company _____
(please present card)

Name of Insured _____
(last) (first) (m.i.)

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured Employer _____

Subscriber # _____ Group # _____

Secondary Insurance

Name of Insurance Company _____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured Employer _____

Subscriber # _____ Group # _____

DENTAL-MEDICAL INFORMATION

	YES	NO		YES	NO
Do you have any general health problems? If so, please specify:	____	____	Have you been hospitalized within the past two years?	____	____
_____			Reason: _____		
Are you currently under a physician's care?	____	____	Are you currently taking any drugs or medication? If so, please list:	____	____
Reason: _____			Reason: _____		
Name of Family Physician: _____			Date of last physical: _____		
Are you allergic to any kind of medication? _____			If so, please list: _____		
_____					

To the best of your knowledge, are you or have you ever been afflicted with any of the following:

	YES	NO		YES	NO
Heart ailment?	____	____	Joint replacement?	____	____
Heart valve replacement?	____	____	Fainting spells?	____	____
Diabetes?	____	____	Prolonged bleeding?	____	____
Rheumatic fever?	____	____	Healing complications?	____	____
Epilepsy?	____	____	Ear problems?	____	____
High blood pressure?	____	____	Nervous or mental problems?	____	____
Respiratory disease?	____	____	Hepatitis?	____	____
Tuberculosis?	____	____	H.I.V. infection?	____	____
Mitral valve prolapse?	____	____	Have you taken Phen / Fen?	____	____

Women: Are you pregnant? _____ If yes, due date: _____

	YES	NO		YES	NO
Do you regularly have any of the following:					
Frequent headaches?	____	____	Upper neck and shoulder pain?	____	____
Sinus pain?	____	____	Hearing or popping sounds?	____	____
Ear pain?	____	____	Jaw locks sometimes?	____	____

When was your last dental appointment? _____ With Whom? _____ For what purpose? _____

What is the purpose of today's appointment? _____

Will today's account be paid by: cash_____ check_____ credit card_____(If you have insurance, your estimated part)

Who is responsible for this patient's account? _____

Whichever comes first, 90 days after treatment or after insurance has made their payment, which credit card do you want the unpaid balance charged to?

☐ Visa ☐ Mastercard ☐ Discover # _____ Exp. Date _____

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 after 60 days. 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 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, 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 agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of Patient, Parent or Guardian

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