

Patient Name		Social Security Number	Home Phone ()	Cell Phone ()
Home Address		City	State	Zip
				Date of Birth / /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		<input type="checkbox"/> Male <input type="checkbox"/> Female		Email Address
Primary Insurance Company		Group	Subscriber: Name	Relationship to patient
				Date of Birth / /
Secondary Insurance Company		Group	Subscriber: Name	Relationship to patient
				Date of Birth / /

Responsible Party Name		Social Security Number	Home Phone ()	Cell Phone ()
Home Address		City	State	Zip
		Relationship to Patient		Drivers License Number and State
Responsible Person's Employer		Occupation		Work Phone ()
Business Address		City	State	Zip
		Email Address		

Spouse's Name		Social Security Number	Date of Birth / /
Spouse's Employer		Spouse's Occupation	Spouse's Work Phone ()
Spouse's Business Address		City	State
		Zip	

In the event of any emergency please contact:

Name: _____ Relationship: _____ Phone: () _____

Name: _____ Relationship: _____ Phone: () _____

Consent

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays which may be deemed necessary and advisable by the doctor.

(Initial) (Date) Relationship to Patient

Terms and Conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. **All dental service performed without prior financial arrangements, must be paid for at the time services are performed.** I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to This Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the even that either this office of I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

(Initial) (Date)

There will be a \$75 fee for any missed appointments or appointments not cancelled 72 hours before the appointment time.

(Initial) (Date)

How did you hear about our Office?

(check only one)

- Referred by a friend
 Yellow Pages
 Relative
 Insurance Plan
 Mail Flyer
 Internet
 Military Guide
 Other _____

If you were referred, whom may we thank for referring you? _____

PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist:(optional) _____ Last Visit: _____ Date of last cleaning: _____

Reason(s) for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? Yes No If yes please, tell us why: _____

Circle Y (Yes) or N (No) as it pertains to your dental history:

- | | |
|--|--|
| Y N I like my smile. | Y N I clench or grind my teeth during the day or while sleeping. |
| Y N I want my teeth whiter. | Y N I have problems eating. |
| Y N I prefer tooth-colored fillings. | Y N I have or had pain in my jaw. |
| Y N I want my teeth straighter. | Y N My gums feel tender or swollen. |
| Y N I have had orthodontics. | Y N My gums bleed while brushing or flossing. |
| Y N I have had a facial or jaw injury. | Y N I avoid brushing part of my mouth due to pain. |

What are your dental priorities?
(e.g.: appearance, dental health, financial considerations, etc.) _____

PATIENT'S MEDICAL HISTORY

Circle Y (Yes) or N (No) as it pertains to your medical history:

- | | |
|--|--|
| Y N Under medical treatment now | Y N Thyroid Disease |
| Y N Hospitalized for surgery or major illness | Y N Cancer Chemo/Radiation Therapy |
| Y N Heart Disease or Attack | Y N Asthma |
| Y N Stroke | Y N Hay-Fever/Allergies or Hives |
| Y N Abnormal Blood pressure (High/Low) | Y N Arthritis/Rheumatism |
| Y N Heart Murmur/Mitral Valve Prolapse (MVP) | Y N Cortisone Medicine |
| Y N Artificial Heart Valve/Pacemaker/Heart Surgery | Y N Epilepsy or Seizure |
| Y N Implant/Artificial Joints (hip, knee, etc.) | Y N Ulcers |
| Y N Blood Thinner/Bleeding Disorders | Y N Herpes (Cold Sores/Fever Blisters) |
| Y N A.I.D.S. or H.I.V. | Y N History of Drug Addiction/Alcohol |
| Y N Immune Suppressed Disorder | Y N History of Emotional / Nervous Disorder |
| Y N Hepatitis Type _____ | Y N History of Psychiatric Emotional Treatment |
| Y N Liver Disease/Jaundice | Y N Smoke/Chew Tobacco |
| Y N Diabetes | Y N Fainting/Dizziness |
| Y N Tuberculosis (TB) or Lung Disease | Y N Other: _____ |
| Y N Kidney Trouble | |

Are you allergic to any of the following?

- | | | |
|-----------------------------------|-------------------------------------|------------------------------------|
| Y N Local Anesthetics (Novocaine) | Y N Penicillin or other antibiotics | Y N Iodine |
| Y N Latex, Metals, Plastics | Y N Codeine or other painkillers | Y N Other Allergies or Medications |
| Y N Aspirin/Ibuprofen | Y N Sulfa Drugs/Sulfites/Sulfides | If Yes, please list: _____ |

Please list all medications you are currently taking:

Medicine: _____ Condition: _____
 Medicine: _____ Condition: _____
 Medicine: _____ Condition: _____
 Medicine: _____ Condition: _____

Women:

Are you taking birth control medication? Y N
 Are you or could you be pregnant or nursing? Y N

Physician's Name: _____ Phone: _____

Address: _____ Fax: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health, medication and/or dental needs.

Patient's Signature

Date

If patient is a minor: Parent/Guardian's Signature

Date