Today's Date:_____ **Today's BP** _____/_____

PATIENT NAME _____ **DATE OF BIRTH**_____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care_____

Former Dentist _____ Date of last dental X-rays_____

Address_____

Home Phone_____Cell Phone_____E-mail Address_____

How did you find out about our office?_____

Are you satisfied with your smile? ☐ YES ☐ NO If not, do you want to improve it? ☐ YES ☐ NO

Check (✓) YES/ NO if you have had problems with the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Bad breath	☐	☐	Grinding teeth	☐	☐	Sensitivity to cold	☐	☐	Sores or growths in mouth	☐	☐
Bleeding gums	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitivity to hot	☐	☐	Swelling	☐	☐
Clicking or popping jaw	☐	☐	Pain	☐	☐	Sensitivity to sweets	☐	☐	Reaction to local anesthetic	☐	☐
Food collecting between teeth	☐	☐	Periodontal treatment	☐	☐	Sensitivity when biting	☐	☐			

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name_____Phone Number_____

Have you had any serious illness or operations? ☐ YES ☐ NO If yes, describe_____

Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, give approximate dates_____

Gender: ☐ Male ☐ Female (Women) Are you pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

Check (✓) YES/NO if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Anemia	☐	☐	Cortisone Treatments	☐	☐	Jaw Pain	☐	☐	Sleep Apnea	☐	☐
Arthritis, Rheumatism	☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Snoring	☐	☐
Artificial Devices or Joints	☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Fainting	☐	☐	Nervous System Problems	☐	☐	Swelling Feet /Ankles	☐	☐
Autoimmune Conditions	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐	Thyroid Problems	☐	☐
Bleeding Problems	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tobacco Habit	☐	☐
Blood Disease	☐	☐	Heart Problems	☐	☐	Psychiatric Treatment	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Radiation Treatment	☐	☐	Ulcer	☐	☐
Chemical Dependency	☐	☐	Hepatitis	☐	☐	Respiratory Disease	☐	☐			
Chemotherapy	☐	☐	High Blood Pressure	☐	☐	Shortness of Breath	☐	☐			
Circulatory Problems	☐	☐	HIV/AIDS	☐	☐	Skin Rash	☐	☐			

OTHER_____

MEDICATIONS

List of medications you are currently taking:

_____

_____

_____

Pharmacy_____ Phone_____

ALLERGIES

	YES	NO		YES	NO
Aspirin	☐	☐	Penicillin	☐	☐
Barbiturates (sleeping pills)	☐	☐	Sulfa	☐	☐
Codeine	☐	☐	Latex	☐	☐
Local Anesthetic	☐	☐	Other_____		

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
PLEASE PRINT NAME of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

_____ _____
Signature of Doctor Date

Today's Date:_____

Today's BP _____/_____

PATIENT NAME:_____ **DATE OF BIRTH**_____
Last First Initial

Address _____ Home Phone_____

_____ Cell Phone_____

E-Mail Address_____

MEDICAL HISTORY UPDATE

Physician's Name_____Phone Number_____

Have you had any serious illness or operations? ☐ YES ☐ NO If yes, describe_____

Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, give approximate dates _____

Gender: ☐ Male ☐ Female (Women) Are you pregnant? ☐ YES NO Nursing? YES NO Taking birth control pills? YES ☐ NO

Check (✓) YES/NO if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Anemia			Cortisone Treatments			Jaw Pain			Sleep Apnea		
Arthritis, Rheumatism			Diabetes			Kidney Disease			Snoring		
Artificial Devices or Joints			Epilepsy			Liver Disease			Stroke		
Asthma			Fainting			Nervous System Problems			Swelling Feet /Ankles		
Autoimmune Conditions			Glaucoma			Osteoporosis			Thyroid Problems		
Bleeding Problems			Headaches			Pacemaker			Tobacco Habit		
Blood Disease			Heart Problems			Psychiatric Treatment			Tuberculosis		
Cancer			Heart Surgery			Radiation Treatment			Ulcer		
Chemical Dependency			Hepatitis			Respiratory Disease					
Chemotherapy			High Blood Pressure			Shortness of Breath					
Circulatory Problems			HIV/AIDS			Skin Rash					

OTHER_____

MEDICATIONS

List of medications you are currently taking:

_____

_____

_____

Pharmacy_____ Phone_____

ALLERGIES

	YES	NO		YES	NO
Aspirin			Penicillin		
Barbiturates (sleeping pills)			Sulfa		
Codeine			Latex		
Local Anesthetic			Other_____		

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
PLEASE PRINT NAME of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

_____ _____
Signature of Doctor Date

PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

Has any member of your family ever been treated in our office ? ☐Yes ☐No

Whom may we thank for referring you to our office ? _____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____ TELEPHONE _____

ADDRESS _____
STREET APT.# CITY STATE ZIP

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No
☐Payment in full at each appointment (cash or personal check)
☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)
Card # _____ Exp. Date _____
☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATION

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Patient Consent to receive Mail and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

Email Address

Do we have your permission to:

Send a recall appointment reminder to your home? Y_____ N_____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y_____ N_____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____
Signature of Patient / Parent or Legal Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

_____ _____
Signature of Patient / Parent or Legal Guardian Date

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section and sign/date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month or 18% APR
Collections fees (up to 42% of the full balance)
Legal fees for collection services

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Name Witnessed By