Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI
Preferred Name_____

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

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell)_____

Best time and place to call_____ _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Medical History

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

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
☐ _____

☐ Have you ever taken Phen-Fen? Also known as Redux or Pondimin.

Please list any prescription or over the counter medications/supplements taken.

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____

- Name of Physician: _____ Phone:_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  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 or before my next appointment.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

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

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Dental History

Reason for initial visit	
Are you currently in pain? ☐yes ☐no	If yes, Where?_____ If yes, How long have you been in pain? _____
Do you now or have you ever experience pain in your jaw joint? ☐ yes ☐ no	Do you floss daily? ☐ yes ☐ no
Brush daily? ☐ yes ☐ no	Type of toothbrush? ☐ hard ☐ medium ☐ soft ☐ Sonicare ☐ other_____
How long do you use a toothbrush before replacing it?	Do your gums ever bleed? ☐ yes ☐ no
Do you have mobility in your teeth? ☐ yes ☐ no	Have you ever had periodontal (gum) disease? ☐ yes ☐ no
Are your teeth sensitive to hot, cold or anything else?_____	Do you still have wisdom teeth?
Previous Dentist	Last Visit date?_____ What was that visit for?_____
Why did you leave your previous dentist?	What did you like most & least about your previous dentist?
Would you like fresher breath? ☐ yes ☐ no	Would you like whiter teeth? ☐ yes ☐ no
Are you happy with the way your smile looks? ☐ yes ☐ no	If not, what would you change?
Do you have any fears/anxieties about dentistry?	Please Explain

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

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

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

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

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

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

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

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 estimates listed for dental care can only be extended for a period of three months from the date of the patient examination. Fee estimates are also subject to change in treatment needs.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for 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 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