4ever teeth

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www.4EVERTEETH.com

Date: / /

Patient Name: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____ Driver's License: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Cell: _____ E-mail _____

Emergency Contact: _____ Phone: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Health Information

Do you have any of the following? Please check those that apply: (All information is confidential.)

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer/Tumors
- ☐ Cigarette Smoking
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease/ Jaundice
- ☐ Mental/Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnant or planning Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Sleep Apnea/Snore
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Any Communicable/ Infectious Diseases
- ☐ AIDS, HIV, other immunosuppression
- ☐ History of Drug or Alcohol Abuse

Are you allergic to any of the following:

- ☐ Antibiotics _____
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Latex
- ☐ Metals
- ☐ Other _____

_____

_____

- Date of last Dental Visit _____ Reason for this visit _____
  Please explain: _____
- 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 Are you taking any medications?
  If yes, please list: _____
- Name of Physician: _____ Phone: _____
- Do you have any other health problems that the doctor should know about? ☐ 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 the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Whom may we thank for referring you? _____

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

Insurance Information

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

Financial arrangements for treatment by this office are made in advance. Payment in full is expected at time of service unless other arrangements are made.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for 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 patient's insurance forms or assist in collecting from insurance companies and will credit any such collections to the patient's account. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.

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 agreements are arranged.

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 the Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended.

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 also grant permission for the release of any information required for treatment or insurance authorization.

We value the time we reserve for our patients' appointments. We require 48 hours notice if you must reschedule an appointment.

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