

**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.)**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> High Blood Pressure                     | <input type="checkbox"/> Stomach Problems                         | <b>Are you allergic to any of the following:</b><br><input type="checkbox"/> Antibiotics _____<br><input type="checkbox"/> Aspirin _____<br><input type="checkbox"/> Codeine _____<br><input type="checkbox"/> Dental Anesthetics _____<br><input type="checkbox"/> Latex _____<br><input type="checkbox"/> Metals _____<br><input type="checkbox"/> Other _____<br>_____<br>_____ |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Kidney Disease                          | <input type="checkbox"/> Stroke                                   |  |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Liver Disease/<br>Jaundice              | <input type="checkbox"/> Tuberculosis                             |  |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Mental/Nervous<br>Disorders             | <input type="checkbox"/> Any Communicable/<br>Infectious Diseases |  |
| <input type="checkbox"/> Cancer/Tumors      | <input type="checkbox"/> Pacemaker                               | <input type="checkbox"/> AIDS, HIV, other<br>immunosuppression    |  |
| <input type="checkbox"/> Cigarette Smoking  | <input type="checkbox"/> Pregnant or planning<br>Due date: _____ | <input type="checkbox"/> History of Drug or<br>Alcohol Abuse      |  |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Radiation Treatment                     |   |  |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Respiratory Problems                    |   |  |
| <input type="checkbox"/> Epilepsy/Seizures  | <input type="checkbox"/> Rheumatic Fever                         |   |  |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Sinus Problems                          |   |  |
| <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Sleep Apnea/Snore                       |   |  |

• 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.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

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.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_