PATIENT INFORMATION
(PLEASE PRINT)

PATIENT

Name: _____ Birth Date: _____
Last First Middle

Referred By _____

If Patient is a minos, give parent's name or guardian's name: _____ Relationship _____

☐ Male ☐ Female Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____ City _____ State _____ Zip _____

SS#: _____ Cell Phone Number _____ Home Phone _____

Employer _____ Position _____ Bus. Phone _____

Bus. Address _____ City _____ State _____ Zip _____

Email Address _____

Who should be notified in case of an emergency _____ Phone: _____

Name of nearest relative not living with you _____ Phone: _____

Purpose of this appointment _____

SPOUSE OR PARENT

Name: _____ Birth Date: _____
Last First Middle

Employer _____ Position _____ Bus. Phone _____

Bus. Address _____ City _____ State _____ Zip _____

SS#: _____ Cell Phone Number _____ Email _____

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No If yes, Complete the following

Name of Insured _____ SS#: _____ Relationship _____

Birth Date _____ Insurance Company _____ Group No. _____

Is patient Covered by other Insurance? ☐ Yes ☐ No If yes, Complete the following

Name of Insured _____ SS#: _____ Relationship _____

Birth Date _____ Insurance Company _____ Group No. _____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advanced. The practice depends upon reimbursement from the patients for the cost 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 service performed without prior financial arrangements must be paid for in cash at the time services are performed, I understand that the dental services furnished to me are charged directly to me and that I am responsible for payment of all dental services. 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. A service charge of 1.5% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of patient's examination. In consideration of the professional services rendered to me,or at my request,by the Doctorand/or his staff, I agree to pay. Therefore, the resonable value of said services to said Doctors,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 reasonable value of said services shall be billed unless objected to by me, in writing within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entiteld 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 of treatment and agree to their content.

Signed _____ Date _____

PLEASE COMPLETE BOTH SIDES

MEDICAL HISTORY

Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes ◯ No ◯ If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes ◯ No ◯ If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes ◯ No ◯ If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes ◯ No ◯ If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes ◯ No ◯ _____

Are you on a special diet? Yes ◯ No ◯ _____

Do you use tobacco? Yes ◯ No ◯

Do you use controlled substances? Yes ◯ No ◯

Women: Are you
☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments _____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health Questionnaire, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs. I also acknowledge that I been Provide a copy of **Dental Material Fact Sheet** adopted on October 17,2001, as well as a copy of the **"Notice of Privacy"** taking effect on April 14, 2003, copies of which will be given to me upon my request. All services are rendered and accepted under the terms and conditions printed on the reverse hereof.

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

Authorization must be signed by the patient, or the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to Patient:_____

FLORA STENGER, D.D.S

SAMUEL AU, D.D.S..

CAROL BASILIO, D.D.S

OLIVER HOFFMAN D.D.S.

Consent for Treatment
Please Read Before Signing

Patient's Name: _____
Last name First Name Initial Date of Birth

I here by authorize Dr. Flora Stenger,

And whomever she may designate as their assistants and associate dentists, to perform upon me the required services, operations and/or procedures initially discussed and listed in the treatment record. I understand that are only tentative treatment plans based on the initial exam, and that changes may occur as services are rendered.

I request and authorize the above to do what they deem necessary if any unforeseen condition arises in the course of these designated operations and/or procedures calling in their judgment for procedures in addition to or different from those initially contemplated.

I consent to the administration of local anesthesia, antibiotics, analgesics or any other drug that may be deemed necessary in my case, and understand that there is always an element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g. allergic reaction), cardiac arrest, and thrombophlebitis (e.g. irrigation and swelling in a vein), pain discoloration and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs.

I am informed and fully understand that in any type of surgery there are certain unavoidable complications. In dentistry, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws and loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbance (e.g. numbness in the mouth and lip tissue), jaw fractures, sinus exposures, swallowing or aspiration of teeth and/or restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal. I realize that that there are possible complications and/or risk associated with any type of dental treatment. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of the operation procedure.

I have provided as accurate and complete medical and personal history as possible including any and all allergies to antibiotics, drugs, medications and food. I will follow any and all instructions as explained and directed to me and permit prescribed procedures.

Patient or Guardian's Signature _____ Date_____

_____ Date_____
(Witness) (Witness Signature)