PATIENT INFORMATION

(This information is necessary for our files and will be considered **CONFIDENTIAL**)

Date___________________

Patient's Name____Age_________ Birth date___________________ □ **Male** □ **Female**

LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian____ Relationship___________________

Residence Address: ____ Zip code: _______________□ Own □Rent

Patient is: □ Married □ Single □ Divorced □ Separated □ Widowed □ Minor E-mail_____________________ Cell Phone ( )______________

Driver's License No._______________________________ Social Security No._______________________________ Res. Phone ( )______________

Employed by____ How long?________ Occupation___________________

Business Address____ Bus. Phone ( )______________

Spouse's Name____Driver's License No.______________________ Soc. Sec. No.______________________

Employed by____ How long?____________ Occupation______________________________

Business Address____ Bus. Phone( )______________________

Name of nearest relative not living with you____ Relationship_________________________

Complete address____ Res. Phone( )______________________

Name of Physician____Phone ( )__________________________

Address City

Former Dentist____Phone ( )__________________________

Address City

Would you like more information regarding *Invisalign*? □ YES □ NO **Why are you changing Dentists**?____

Do you have any cosmetic concerns re: your teeth?____

Is this office visit for Emergency Dental Care? □ YES □ NO **If YES, explain**____

Whom may we thank for referring you?____School Children Attend________________________________

FINANCIAL INFORMATION

Person responsible for this account______________________________________ Relationship_____________________________( )______________

TELEPHONE

Address____( )______________

STREET CITY ZIP CELL PHONE

PREFERENCE OF PAYMENT: □ CASH on day of treatment □ VISA □ MASTERCARD □ AMEX □ CARE CREDIT

Name of Ins. Co.____

Insured person's name____

BIRTHDATE RELATIONSHIP SOC SEC NO

____

TERMS AND CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. 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 dental services furnished to me are charged directly to me and that I am personally 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.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1 1/2% 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 extimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of 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 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 entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

Less than 24 hour notice of schedule changes or not showing for an appointment is considered a broken appointment and will incur a $40 fee for a 1 hour appointment. The fee is greater for long appoints.

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:________________________________

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

HEALTH QUESIONAIRE

Dr. Bailey is asking these questions for your benefit and assures that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please leave ***no answer blank***, check the appropriate box and/or circle **YES** or **NO** where applicable. Example: Are you alive?........................YES NO

1. Are you in good health?..YES NO
2. Date of last physical examination__________________________________
3. Are you now under the care of a physician?..YES NO
   If so, what is the condition being treated?__________________________________
4. Have you ever had any serious illness or operation?..YES NO
   If so, what illness or operation?__________________________________
5. Have you ever been hospitalized?..YES NO
   If so, what was the problem?__________________________________
6. Are you taking any □ medications, □ drugs or □ herbs?..YES NO
   If so, what?____________________What dosage?____________________
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? □ YES □ NO If so, what?____________________
8. Have you ever been premedicated with antibiotics for your dental treatment?..YES NO
9. Are you sensitive or allergic to any drugs or materials?□Penicillin;□Tetracycline;□Sulfa Drugs;□Aspirin;□Codeine;□Latex;□Other?........YES NO
   If other, what?__________________________________
10. Do you have or have you had any of the following in the box below: (Please circle "**Y**" for Yes or "**N**" for No - answer all conditions):

Y N Anemia	**Y N** Hay Fever	**Y N** Head Injuries	**Y N** Cerebral Palsy	**Y N** Rheumatic Fever
Y N Sickle Cell Disease	**Y N** Herpes	**Y N** Glaucoma	**Y N** Heart Failure	**Y N** Drug addiction
Y N Tuberculosis (TB)	**Y N** Cortisone Medication	**Y N** Stroke	**Y N** Tonsillitis	**Y N** Scarlet Fever
Y N Kidney Disease	**Y N** Blood Transfusion	**Y N** Allergies to Metals	**Y N** Difficulty Swallowing	**Y N** Ulcers
Y N Hemophilia	**Y N** Sinus Trouble	**Y N** Chemotherapy	**Y N** Joint Replacement	**Y N** Excessive Bleeding
Y N Diabetes	**Y N** Cold Sores	**Y N** Heart Murmur	**Y N** Stomach Ulcers	**Y N** Nervous Disorders
Y N Mitral Valve Prolapse	**Y N** Arthritis	**Y N** Emphysema	**Y N** Liver Disease	**Y N** Angina Pectoris
Y N High Blood Pressure	**Y N** Asthma	**Y N** Rheumatism	**Y N** Blood Disease	**Y N** Mental Disorder
Y N Allergies or Hives	**Y N** HIV Related Complex	**Y N** Cancer	**Y N** Chicken Pox	**Y N** Heart Ailments
Y N Thyroid Disease	**Y N** Pain in Jaw Joints	**Y N** Respiratory Disease	**Y N** Seizures	**Y N** Bruise Easily
Y N Heart Attack	**Y N** Fainting Spells	**Y N** Artificial Prosthesis	**Y N** Epilepsy or Seizures	
Y N Tumors or Growths	**Y N** Hepatitis or Jaundice	**Y N** Psychiatric Treatment	**Y N** Congenital Heart Lesions	
Y N X-Ray or Cobalt Treatment		**Y N** Venereal Disease (Syphilis, Gonorrhea)		
Y N Acquired Immune Deficiency Syn. (AIDS)		**Y N** Radiation Treatment of any kind		
Y N TMJ (Temporal Mandibular) Disorder				

11. Do you have any disease, condition or problem not listed that you think we should know about?..YES NO
    If so, what?__________________________________
12. Do you wear a cardiac pacemaker?..YES NO
13. Do you smoke? If yes, how much____________ □ cigarettes □ cigars □ packs per day……………………………YES NO
14. Have you ever taken the drugs □ Phen-phen, □ Redux or any □ diet drugs? ……………………………YES NO
15. (Women) Do you have any problems associated with your menstrual period?..YES NO
16. (Women) Are you pregnant? If so, how many months?____________________.....................................YES NO
17. (Women)Do you take any birth control medication or hormones?..YES NO

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc)……………………………......YES NO
2. Have you ever had any unfavorable reaction from a local anethetic?..YES NO
3. Have you had any serious trouble associated with any previous dental treatment?..YES NO
   If so, explain?__________________________________
4. How long since your last full mouth x-Rays?_______Weeks_________Months__________Years
5. How long since your last dental treatment? _______Weeks_________Months__________Years
6. Does dental treatment make you nervous? □ slightly □ moderately □ extremely?..YES NO
7. Do you prefer nitrous oxide?..YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment. I hereby authorize Dr. Gerald W. Bailey to take photographs, slides and / or videos of my face, jaws and teeth. I understand that the photographs, slides, and / or videos will be used as a record of my care and my be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

DATE____________ Signature__________________________________

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 History Form, to administer such anesthetics, analgesics, sedatives, nitrous oxide 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.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

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

Signed:__________________________________ Date:____________________ Relationship to patient:____________________