

Thank you for visiting Dentistry By Drs. Dolas. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET Male Female
 Married Single

CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____

Phone: Home (____) _____ **Social Security #** _____
 Work (____) _____ email _____
 Mobile(____) _____

Emergency: Name _____ Phone (____) _____

Insurance / Consent

Primary Carrier

Subscriber Name _____ Social Security # _____ DOB _____
 Employer _____ Insurance Co. _____
 Insurance Co. Phone # _____ Group # _____
 Relation to patient _____

Secondary Carrier

Subscriber Name _____ Social Security # _____ DOB _____
 Employer _____ Insurance Co. _____
 Insurance Co. Phone # _____ Group # _____
 Relation to patient _____

Consent Statement and Insurance Authorization (Sign & Date)

I understand that I am responsible for all costs and dental treatment.
 I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care and records. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. **Service Charge:** If I do not pay the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 2% per month or a minimum charge of \$3.00 for a balance under \$200.00) which is an annual percentage rate of 24% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

The information on this page is correct to the best of my knowledge.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

CITY STATE ZIP Telephone

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

Have your teeth ever embarrassed you in the last year? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

Have you had problems with prior dental treatment? _____

Is your general health good? _____

Medical History and Information

Do you have or have you ever had?

Yes No

- Arthritis
- Asthma
- Allergies to: drugs, foods, medications, latex
- Sinus problems
- Epilepsy
- Glaucoma
- Tumors, Cancer
- Chemotherapy/Radiation treatment
- Treatment with Biphosphonates
- Heart Problems/ Heart Murmur
- High Blood Pressure
- Pacemaker/Prosthetic Heart Valve
- Diabetes
- Jaundice/ Hepatitis
- Kidney Problems
- HIV Positive/AIDS
- Psychiatric Treatment
- Rheumatic Fever
- Sexually Transmitted Diseases
- Stroke
- TB/Emphysema/other lung disease
- Surgery/Blood transfusions
- Other

Are you allergic to?

Yes No

- Aspirin
- Barbiturate
- Codeine
- Penicillin
- Other

Are you currently under the care of a physician? Y N

Please explain:

Are you taking:

Drugs or medications? Yes No

Recreational Drugs? Yes No

Tobacaco in any Form? Yes No

If YES, please list:

Are you taking any drugs or medications? Yes No

Female Patients: Are you pregnant? Yes No

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE