

Name: \_\_\_\_\_ HM: \_\_\_\_\_ WK \_\_\_\_\_

CELL #: \_\_\_\_\_

Address: \_\_\_\_\_ City, State \_\_\_\_\_

Zip Code: \_\_\_\_\_

**HAVE YOU EVER HAD:**

- Hepatitis
- Liver Disease
- Epilepsy
- Seizures
- Rheumatic Fever
- Kidney Disease
- Diabetes
- Tuberculosis
- Heart Trouble
- Damage Heart Valves
- Artificial Heart Valves
- Congenital Heart Lesions
- Coronary Insufficiency
- Coronary Occlusion
- Arteriosclerosis
- Stroke
- Cardiac Pacemaker
- Heart Murmur
- High Blood Pressure
- Low Blood Pressure
- Shortness of Breath
- Chest Pains
- Medical Treatment by X-Ray
- Venereal Disease
- Surgery
- Glaucoma
- Prostate Trouble
- Contact Lenses
- Drug Reaction
- Psychiatric Treatment
- Burning Tongue
- Ulcer
- Sinus Problems
- Asthma
- Treatment for Tumor/Growth
- Prosthetic Replacement (Hip, Knee, etc.)
- HIV Positive

**An Unfavorable Reaction to a Drug Such As:**

- Aspirin
- Barbiturates
- Anesthetics
- Penicillin
- Sulfa Drugs
- Codeine
- Other

**Has A Member of your family:**

Had Diabetes?  
Who? \_\_\_\_\_

At What Age? \_\_\_\_\_

**IF FEMALE ARE YOU NOW:**

- Pregnant  
Due Date \_\_\_\_\_
- Taking anti-pregnancy drug
- Presently in the Menopause
- Past Menopause

**ARE YOU:**

- Presently under the care of a physician
- Taking any medication now  
List of Current Medications

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Or within the past year such as:**

- Anticoagulants
- Cortisone
- Tranquilizers
- Nitroglycerin
- Penicillin
- Aspirin Daily
- Digitalis, heart medicine
- Medication for High Blood Pressure
- Allergic to Dental Anesthetic
- Aware of recent weight change
- Subject to frequent urination
- Often thirsty
- Subject to frequent headaches
- Easily exhausted or fatigued
- Slow in healing
- In good health now
- Aware of grinding or clenching your teeth day or night
- Satisfied with the appearance of your teeth

**HAVE YOU:**

- Ever been told you had gum trouble
- Ever had trench mouth
- Ever been treated for Periodontal Disease (Phorrhea)
- Ever had Orthodontic Treatment
- Had shifting of any teeth

**DO YOU:**

- Ever have sore or popping joints
- Ever have sore teeth
- Ever notice your ankles swell
- Have prolonged bleeding after injury or tooth extraction
- Have a persistent cough or cough up blood
- Get short of breath when you lie down or require extra pillows when you sleep
- Have any blood disorder
- SMOKE

\_\_\_\_\_  USE DRUGS

\_\_\_\_\_  USE ALCOHOL

**Have habits such as:**

- Pencil chewing
- Fingernail biting
- Pipe smoking
- Have unpleasant tastes in your mouth
- Have bleeding gums
- Have bad breath
- Have tooth sensitivity to heat
- Have tooth sensitivity to cold
- Have tooth sensitivity to sweets
- Use dental floss
- Have any fear of dental treatment
- Want to keep your teeth
- Yes, no matter how much trouble
- Yes, if it's not too much trouble
- Any serious illness not listed

If so, explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

**Consent for Services**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs 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 services performed without previous financial arrangements, must be paid for in cash 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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

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 arrangements are satisfied.

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 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 as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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 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**