

PATIENT HISTORY & INFORMATION

**Welcome to our office. We are pleased to have the opportunity to treat your dental needs.
Please fill out the information on this page for our records.**

Patient Name: _____ Today's Date: _____
Mailing Address: _____ Birth Date: _____
City: _____ State: _____ Zip: _____ Age: _____ Sex: F M
Physical Address: _____ Marital Status: (circle one)
City: _____ State: _____ Zip: _____ Single Married Child
Phone: (H): _____ (W): _____ (Cell): _____
Email: _____
Whom may we thank for referring you to our office? _____
Preferred Pharmacy: _____ Phone: _____
Employer: _____ Occupation: _____
Person Responsible for Payment: ___ Patient ___ Parent ___ Spouse Name: (if not Patient) _____
Does Patient have Dental Insurance Coverage? (circle one) YES NO
Insured Member's Name: _____ Insured Member's Birth Date: _____
Insured Member's Social Security # OR Insurance Subscriber ID #: _____
Person to contact in case of emergency: _____
Relationship to Patient: _____ Phone: _____
 Check here if same as Patient's address.
Address: _____ City: _____ State: _____ Zip: _____

DENTAL HISTORY INFORMATION

YES NO Do you have a specific problem that needs attention now? _____
YES NO Have you had regular dental checkups? _____
When was your last dental visit? _____ What was done then? _____
YES NO Do your gums bleed when brushing or flossing? _____
YES NO Have you ever been treated for a gum problem? _____
YES NO Have you lost any teeth? Why? _____
YES NO Do you feel you will eventually lose all your teeth? _____
YES NO Are you apprehensive about receiving dental treatment? _____
YES NO Have there been any complications during previous dental treatment? _____

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I consent to treatment as necessary or desirable to the care of the patient named above, for the diagnosis of dental disease or treatment of dental emergency. These procedures may include radiographs, models and intraoral examination. In the case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance. I give my consent to the use of local anesthetic and relaxants for completing the necessary dental treatment. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, **at the time of service**, regardless of insurance coverage. Accounts 30 days past due will accrue at 1.5% finance charge per month. I agree to pay all reasonable attorney's fees and costs incurred by this office if my account is turned over to a lawyer for collection. I have been notified of this office's Privacy Policy Practices and been given the opportunity to read them in full.

Signed: _____ Date: _____
Printed Name: _____