

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name) Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street PO Box Apartment #  
City State Zip Code

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please circle Y or N**

Y or N AIDS	Y or N Excessive Bleeding	Y or N Liver Disease	Y or N Stomach Problems
Y or N Allergies	Y or N Fainting	Y or N Mental Disorders	Y or N Stroke
_____	Y or N Glaucoma	Y or N Nervous Disorders	Y or N Tuberculosis
Y or N Anemia	Y or N Growths	Y or N Pacemaker	Y or N Tumors
Y or N Arthritis	Y or N Hay Fever	Y or N Pregnant Now	Y or N Ulcers
Y or N Artificial Joints	Y or N Head Injuries	Due date: _____	Y or N Venereal Disease
Y or N Asthma	Y or N Heart Disease	Y or N Radiation Treatment	Y or N Codeine Allergy
Y or N Blood Disease	Y or N Heart Murmur	Y or N Respiratory Problems	Y or N Penicillin Allergy
Y or N Cancer	Y or N Hepatitis	Y or N Rheumatic Fever	OTHER:
Y or N Diabetes	Y or N High Blood Pressure	Y or N Rheumatism	<input type="checkbox"/> _____
Y or N Dizziness	Y or N Jaundice	Y or N Sinus Problems	<input type="checkbox"/> _____
Y or N Epilepsy	Y or N Kidney Disease		

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician (other than routine checkups)?  Yes  No  
If yes, please explain: \_\_\_\_\_  
Are you taking any **medications**?  Yes  No \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have other conditions not mentioned above?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

**X** \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of patient, parent or guardian

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  Internet  Work  Other \_\_\_\_\_  
Name of person or office referring you to our practice: \_\_\_\_\_

### Responsible Party Information

The following person is responsible for the account:  self  other

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Employment Information

Name of Patient's (or Insured's) Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City, State Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

**Primary**  
Name of Insured (Person Carrying Insurance): \_\_\_\_\_  
Is insured also a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Company Name and Address: \_\_\_\_\_

**Secondary**  
Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Company Name and Address: \_\_\_\_\_

### 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. I authorize release of any information relating to dental treatment to my dental 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.

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 acknowledge receipt of this offices' posted Notice of Privacy Practices (HIPAA). 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.

**X** \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of guarantor of payment/responsible party