

**Patient Information**

Patient Name: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (MI) (Preferred Name)

 Male Female Marital Status: Single Married Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone (Home): (Work): ext.\_\_\_\_\_\_\_ (Cell):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

 Street Apartment #

 City State Zip Code

**Health Information**

Date of Last Dental Visit: Reason for this visit:

Are you happy with your smile or what would you change about your smile? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

|  |
| --- |
|  AIDS/HIV |
|  Allergies \_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_\_\_\_\_\_ |
|  Anemia  |
|  Arthritis |
|  Artificial Joints |
|  Asthma |
|  Blood Disease |
|  Cancer Chemotherapy  |
|  Diabetes |
|  Dizziness |
|  Epilepsy |
|  Excessive Bleeding |
|  Fainting |
|  Glaucoma |
|  Latex Allergy |
|  Head Injuries |
|  Heart Disease |
|  Heart Murmur |
|  Hepatitis C or B |
|  High Blood Pressure |
|  Jaundice |
|  Joint Replacement  Kidney Disease |
|  Liver Disease |
|  Mental Disorders |
|  Nervous Disorders |
|  Pacemaker |
|  Pregnancy |
|  Due date:\_\_\_\_\_\_\_\_\_ |
|  Radiation Treatment |
|  Respiratory Problems |
|  Rheumatic Fever |
|  Stomach Problems |
|  Stroke |
|  Tuberculosis |
|  Tumors |
|  Ulcers |
|  Venereal Disease |
|  Codeine Allergy |
|  Penicillin Allergy |
| **Any other allergy or information**:  |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

• 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?  Yes  No

 If yes, please explain:

• Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

• Do you currently take any medications?  Yes  No

 If yes, please list:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

\*You May Refuse to Sign This Acknowledgement\*

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of this office’s Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date)

**Spouse or Responsible Party Information, IF other than Patient**

The following is for:  the patient's spouse  the person responsible for payment

Name*,*

  Male  Female  Married  Single  Child  Other

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

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_ Cell:

Address:

 Street Apartment # City State Zip Code

**Employment Information**

The following is for:  the patient  the person responsible for payment

Employer Name: Occupation:

Address:

 Street City, State Zip Code Phone

**Insurance Information**

***Primary***

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

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 Plan Name and Address:

Insurance Company Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Insured a patient? Yes No

***Secondary***

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

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 Plan Name and Address:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Insured a patient? Yes No

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

Signature of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:

Signature of guarantor of payment/responsible party