



Welcome To Our Office Where You Can Expect The BEST!

(1) Patient Information

Patient Name: _____ Date: _____
Family Status: M, S, W, Other Gender: M, F Occupation: _____
SSN: _____ Birth Date: ____/____/____ Email Address: _____
Phone #'s: Home: _____ Cell: _____ Work: _____ Ext: _____
Address: _____
Street Apartment # City State Zip Code

(2) Health Information

Date of last visit to a dentist: _____ Reason for today's visit: _____

Do you have any of the following conditions?

Yes / No Yes / No Yes / No Yes / No
AIDS (HIV+) Fainting Mental Disorders Stomach Problems
Allergies Glaucoma Nervous Disorders Taken Phen Phen
Anemia Growths Pacemaker Tuberculosis
Arthritis Hay Fever Pregnancy due: Tumors
Artificial Joints Head Injuries Previous Stroke Ulcers
Asthma Heart Disease Radiation Treatment Venereal Disease
Blood Disease Heart Murmur Respiratory Problems
Cancer Hepatitis Rheumatic Fever
Diabetes High Blood Pressure Rheumatism
Dizziness Jaundice Sinus Problems
Epilepsy Kidney Disease Sleep Apnea
Excessive Bleeding Liver Disease Smoking Habit

Allergies: (Penicillin, Codein, Latex, Nickel, Sulfa, etc.):

- Person to contact in case of an emergency: _____ Phone # () -
Have you had any complications following dental treatment? YES NO Please explain:
Have you been admitted to a hospital or needed emergency care in the past 2 years? YES NO
If YES, please explain:
Are you now under a physician's care? YES NO If YES, please explain:
Name of physician: _____ Phone # () -
Are you taking any medication(s)? YES NO Please list:
Anything else that you would like us to know about you?

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 before the next appointment without fail.

Signature of Patient, Parent, or Guardian Date:
Signature of Dentist Date:

(3) Referral Information

Whom may we thank for referring you to our practice? Another patient Insurance Ad Other
Name of person or office referring you to our practice:

(4) Spouse or Responsible Party Information

The following is for: Patient's Spouse Person responsible for payment

Name: _____
 Male Female Married Single Widowed Other _____

Social Security #: _____ Birth Date: _____ Occupation: _____

Phone# (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment # City State Zip Code

Employer Name/Address: _____

(5) Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

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

Insured's Address: _____
Street Apt# City State Zip Code

Insured's Employer's Name & Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan 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 Apt# City State Zip Code

Insured's Employer's Name & Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

(6) Consent for Treatment To Be Done

I understand that I am having the following treatment: Exam X-Rays Cleaning (Prophylaxis) Filling(s) Crown(s) Extraction(s)
 Root Canal Dentures Invisalign Zoom
 Other _____ **Please initial**

I would also like to learn about ways to improve my: (please circle) SMILE , BITE , TEETH COLOR , TEETH SHAPE , OTHER _____

(7) 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; thus, 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 patient's 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 any 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 3 (three) months from the date of examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or her 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 and/or your assignee, to email me, send mail to my home/work, and telephone me at home/my cell/ my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

I have received a copy of the Dental Materials Facts Sheet as required by law. **Please initial**

Signature of patient, parent, or guardian _____ Date: _____ Relationship to Patient: _____

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