Patient Information

Date: _____

Patient Name: _____ Social Security #: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____ Age: _____ Birth Date: _____

E-mail: _____ Height: _____ Weight: _____

Phone (Cell): _____ (Work): _____ Ext: _____ (Home/Other): _____

Address: _____ Emergency contact: _____
Street Apartment #

_____ Emergency phone: _____
City State Zip Code

Employer: _____ Occupation: _____

Health and Dental Information

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

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Headaches
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Jaw Problems
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Sleeping Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ 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: _____
- Please list any medications you are currently taking:

_____

_____

- Please list any medication allergies: _____

Information for Responsible Party

(If other than Patient or Insured)

Name: _____ Social Security #: _____ Birth Date: _____

☐ Male ☐ Female Relationship to patient: _____

Phone (Cell): _____ (Work): _____ Ext: _____ (Home/Other): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer: _____ Occupation: _____

Referral Information

Whom may we thank for referring you to our practice? _____

☐ Internet ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Insurance Information

Primary

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

_____

Secondary

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

(The patient is responsible for filing claims with insurance companies additional to those stated above.)

Financial Responsibility and 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. The costs incurred include fees for services, insurance deductibles and co-pays, and cost of goods sold.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that this office will prepare and file the patient's insurance forms for up to two insurances. Any collections from insurance companies will be applied to the patient's account. Any amount not covered by the insurance company is the responsibility of the patient and will be collected at the time of service or billed to the patient for immediate payment. Balances older than 30 days may be subject to additional collection fees, unless previously written financial arrangements are satisfied.

Dental estimates may be provided prior to treatment. This is not a guarantee, but an estimate. 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.

You have the right to request and read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

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 contact information, health or dental information, or insurance coverage, I will inform you or your assignee as soon as possible.

I grant my permission to allow you or your assignee to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

I grant my permission to you or your assignee, to contact me 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