PATIENT INFORMATION

(This information is necessary for our files and will be considered **CONFIDENTIAL**)

Date _____

Patient's Name _____ (LAST / FIRST / INITIAL) Age _____ Birthday _____

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ (STREET / CITY / ZIP) For how long? _____ ☐ Own ☐ Rent

Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Driver's License No. _____ Social Security No. _____ Res. Phone ( ) _____

Bank _____ Account No. _____ Patient's Birthdate _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Spouse's Name _____ Driver's License No. _____ Soc. Sec. No. _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ (STREET / CITY / ZIP) Res. Phone ( ) _____

Name of Physician _____ (ADDRESS / CITY / TELEPHONE)

Former Dentist _____ (ADDRESS / CITY / TELEPHONE)

Purpose of Appointment _____

Is this office visit for Emergency Dental Care? ☐ Yes ☐ No If yes, explain: _____

School Children Attend _____ Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address _____ (STREET / CITY / ZIP / TELEPHONE)

PREFERENCE OF PAYMENT: ☐ Cash on day of treatment ☐ Visa No. _____

☐ State Aid No. _____ ☐ Mastercard No. _____

Name of insurance company (primary insurance) _____

INSURED PERSON'S NAME / BIRTHDATE / RELATIONSHIP / SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL

Name of insurance company (secondary insurance) _____

INSURED PERSON'S NAME / BIRTHDATE / RELATIONSHIP / SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL

TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and or his staff, 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees.

I grant my permission to you, or your assigns, 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 agree to their content.

Signed _____ Date: _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐

	Yes	No
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

REVIEWED BY

2 YEAR 5

3 YEAR 6

4 YEAR 7

Date_____ **Signature**_____

Year 2
Changes in Health _____

Date_____ **Signature**_____

Year 3
Changes in Health _____

Date_____ **Signature**_____

Date_____ **Signature**_____

Year 5
Changes in Health _____

Date_____ **Signature**_____

Year 6
Changes in Health _____

Date_____ **Signature**_____

Health Questionnaire MUST be updated every year!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs. **All services are rendered and accepted under the terms and conditions printed on the reverse hereof**

Signed: _____ Date: _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____