

Today's Date: _____

Today's BP _____ / _____

PATIENT NAME _____ DATE OF BIRTH _____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Home Phone _____ Cell Phone _____ E-mail Address _____

How did you find out about our office? _____

Are you satisfied with your smile? YES NO If not, do you want to improve it? YES NO

Check (✓) YES/ NO if you have had problems with the following:

YES	NO	YES	NO	YES	NO	YES	NO
Bad breath		Grinding teeth		Sensitivity to cold		Sores or growths in mouth	
Bleeding gums		Loose teeth or broken fillings		Sensitivity to hot		Swelling	
Clicking or popping jaw		Pain		Sensitivity to sweets		Reaction to local anesthetic	
Food collecting between teeth		Periodontal treatment		Sensitivity when biting			

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Have you had any serious illness or operations? YES NO If yes, describe _____

Have you ever had a blood transfusion? YES NO If yes, give approximate dates _____

Gender: Male Female (Women) Are you pregnant? YES NO Nursing? YES NO Taking birth control pills? YES NO

Check (✓) YES/NO if you have or have had any of the following:

YES	NO	YES	NO	YES	NO	YES	NO
Anemia		Cortisone Treatments		Jaw Pain		Sleep Apnea	
Arthritis, Rheumatism		Diabetes		Kidney Disease		Snoring	
Artificial Devices or Joints		Epilepsy		Liver Disease		Stroke	
Asthma		Fainting		Nervous System Problems		Swelling Feet /Ankles	
Autoimmune Conditions		Glaucoma		Osteoporosis		Thyroid Problems	
Bleeding Problems		Headaches		Pacemaker		Tobacco Habit	
Blood Disease		Heart Problems		Psychiatric Treatment		Tuberculosis	
Cancer		Heart Surgery		Radiation Treatment		Ulcer	
Chemical Dependency		Hepatitis		Respiratory Disease			
Chemotherapy		High Blood Pressure		Shortness of Breath			
Circulatory Problems		HIV/AIDS		Skin Rash			

OTHER _____

MEDICATIONS

List of medications you are currently taking:

Pharmacy _____ Phone _____

ALLERGIES

YES	NO	YES	NO
		Penicillin	
		Sulfa	
		Latex	
		Other _____	

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative _____

Date _____

PLEASE PRINT NAME of Patient, Parent, Guardian, or Personal Representative _____

Relationship to Patient _____

Signature of Doctor _____

Date _____

Today's Date: _____

Today's BP _____ / _____

PATIENT NAME: _____
Last First Initial

DATE OF BIRTH _____

Address _____

Home Phone _____

Cell Phone _____

E-Mail Address _____

MEDICAL HISTORY UPDATE

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Chemotherapy			High Blood Pressure		Shortness of Breath			
Circulatory Problems			HIV/AIDS		Skin Rash			

OTHER _____

MEDICATIONS

ALLERGIES

List of medications you are currently taking:

Pharmacy _____ Phone _____

Aspirin
Barbiturates (sleeping pills)
Codeine
Local Anesthetic

YES NO

Penicillin
Sulfa
Latex
Other _____

YES NO

SIGNATURE

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Date _____

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Relationship to Patient _____

Signature of Doctor _____

Date _____

DENTAL HEALTH HISTORY

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIPBIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER**INSURANCE INFORMATION**MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED**PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY**

LAST	FIRST	M	
STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)	RELATIONSHIP TO PATIENT		
EMPLOYER	DENTAL INS. CO		
SS#	SUBSCRIBER #	GROUP #	

Has any member of your family ever been treated in our office ? Yes No

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

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____ TELEPHONE _____

ADDRESS _____
STREET APT.# CITY STATE ZIP**METHOD OF PAYMENT**Responsible party currently has an account with this office
Yes No
Payment in full at each appointment (cash or personal check)
Payment in full at each appointment (VISA MC OTHER)
Card # _____ Exp. Date _____
I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATION

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

Patient Consent to receive Mail and/or Telephone Messages

Please Print (Last Name)

(First Name)

(M.I.)

Email Address

Do we have your permission to:

Send a recall appointment reminder to your home? Y____ N____

Leave appointment, billing or dental information on
your answering machine/voice mail/e-mail: Y____ N____

I give permission to share appointment, billing or dental information with the person named
below:

Name: _____

Signature of Patient / Parent or Legal Guardian

Date

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14,
2003.

Signature of Patient / Parent or Legal Guardian

Date

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section and sign/date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_____ There will be a fee of \$30.00 for any checks returned as Non-Sufficient Funds (NSF)

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month or 18% APR

Collections fees (up to 42% of the full balance)

Legal fees for collection services

Signature of Patient or Guardian

Date

Print Name

Witnessed By