



**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ E-Mail: \_\_\_\_\_

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

In case of Emergency, contact: Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

**Health Information**

Previous Dentist: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Date of Last x-rays: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

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

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Lung Disease                | <input type="checkbox"/> Tobacco Usage            |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Growths             | <input type="checkbox"/> Mental Disorders            | <input type="checkbox"/> Tuberculosis             |
|   | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Mitral Valve Prolapse (MVP) | <input type="checkbox"/> Tumors                   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Nervous Disorders           | <input type="checkbox"/> Ulcers                   |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Venereal Disease         |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Heart Defect        | <input type="checkbox"/> Pregnancy                   | <input type="checkbox"/> Antibiotics Allergy      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Heart Disease       | Due: _____   | <input type="checkbox"/> Codeine Allergy          |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Prescribed Weight Loss Med  | <input type="checkbox"/> Latex Allergy            |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Radiation Treatment         | <input type="checkbox"/> Penicillin Allergy       |
| <input type="checkbox"/> Chest Pain         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems        | <input type="checkbox"/> Other Anesthetic Allergy |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Rheumatic Fever             |   |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Rheumatism                  | OTHER:  |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Joint Replacement   | <input type="checkbox"/> Sinus Problems              | <input type="checkbox"/> _____                    |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems            | <input type="checkbox"/> _____                    |
| <input type="checkbox"/> Fainting           | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> _____                    |

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 have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

Are you taking any medications? Please List: \_\_\_\_\_

What is your primary source of water?  Well  County  
Do you pre-medicate for dental appointments?  Yes  No If so, why \_\_\_\_\_

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 doctor at the next appointment without fail.

\_\_\_\_\_ Date: \_\_\_\_\_

### Cosmetic Information

Is there anything about your smile that you do not like? \_\_\_\_\_

Are you interested in knowing the options available for a more beautiful smile? \_\_\_\_\_

Do you like the appearance of your teeth? \_\_\_\_\_

Are all of your teeth in alignment (straight)? \_\_\_\_\_

Do you have any missing teeth? \_\_\_\_\_ Are any chipped? \_\_\_\_\_

Is your bite comfortable when chewing, biting? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_

Do you have any old fillings or dental treatment that you are unhappy with? \_\_\_\_\_

What would you like to change the most about the appearance of your teeth? \_\_\_\_\_

\_\_\_\_\_

Is there anything else that you would like us to know? \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another Doctor

Radio ad  Elan Magazine  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Spouse or Responsible Party Information

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: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

**Insurance Information**

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

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

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Telephone: \_\_\_\_\_

**Assignment of Benefits**

I authorize payment of dental benefits to the named provider for professional services rendered.

Name \_\_\_\_\_ Date \_\_\_\_\_

**Assignment of Benefits**

I authorize the release of any dental information necessary to process claims

Name \_\_\_\_\_ Date \_\_\_\_\_

**Consent for Services**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

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 an insurance company.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) 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 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.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

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.

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