PATIENT INFORMATION

Patient Name:_____ Date:_____

Male___ Female____ married____ Single____ Child____ Other____ Email:_____

Social Security # :_____-_____-_____ Birth date: _____

Phone (home) :_____ Work:_____

Cell :_____ Other: _____

Address :_____

City: _____ Sate: _____ Zip: _____

DATE OF LAST DENTAL VISIT: _____ REASON FOR VISIT: _____

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

Aids/HIV__	Excessive Bleeding__	Jaundice__	Sinus Problems__
Allergies__	Fainting__	Kidney Disease__	Stomach Problems__
Anemia__	Glaucoma__	Liver Disease__	Stroke__
Arthritis__	Growths__	Mental Disorders__	Tuberculosis__
Artificial Joints__	Hay Fever__	Nervous Disorders__	Ulcers__
Asthma__	Head Injuries__	Pacemaker__	Tumors__
Blood disease__	Heart Disease__	Pregnancy__	Venereal Disease__
Diabetes__	Heart Murmur__	Radiation Treatment__	Codeine Allergy__
Dizziness__	Hepatitis__	Respiratory Problems__	Penicillin Allergy__
Epilepsy__	High Blood Pressure__	Rheumatism__	Other:_____

- Have you ever had any complications following dental treatment? Yes__ No__

_____

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes__ No__

_____

- Are you now under the care of a physician? Yes__ No__

_____

- What medications (if any) are you currently taking)?

_____

- Do you need to be pre-medicated with antibiotics prior to having dental work done?

_____

- Name of Physician :_____ Phone:_____

- Do you have any health problems that need further clarification ? Yes__ No__

_____

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.

Signature:_____

Date:_____

Whom may we thank for referring you to our practice?

_____

Responsible party Information- MUST BE FILLED OUT COMPLETLEY

Name:_____

Social Security #:___-___-___ Birth date: _____

Phone (home):_____ Work: _____ Cell:_____

Address:_____

City:_____ State:_____ Zip:_____

Employment Information

The following is for: the patient_____, the person responsible for payment_____

Employer Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Insurance Information

Primary: Name of insured:_____ is insured a patient? Yes_____, No _____

Insured's Birth date: _____ ID #: _____ Group #: _____

Insured's address: _____ City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Address: _____ City: _____ State: _____ State: _____

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 #: _____

Insured's address: _____ City: _____ State: _____ Zip: _____

Insured's employer name: _____

Insured's employer address: _____ City: _____ State: _____ Zip: _____

Consent for Service

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.

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 for all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients 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 1/12 % 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 pre estimate listed for this dental care can only be extended for a period of six months from the date of the patients 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 the said services to said doctor, or his assignee, at the said services or 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 of payment thereof.

I further agree that a waiver of any breech of any time of 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 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 agreed to their content.

Signature:_____Date:_____

Signature of responsibility party:

_____Date:_____