

Patient Information

Patient Name: _____ **Date:** _____
Last, First MI (Preferred Name)
Gender (circle): Male / Female **Marriage Status** _____
Social Security #: _____ **Birth Date:** _____
Phone (Home): _____ **(Work):** _____ **(Cell):** _____ **Check Preferred Number to call**
 Home Work Cell
Email Address: _____
Home Address: _____
Street City State Zip Code
Employer Name: _____ **Occupation:** _____
Employer Address: _____
Street City State Zip Code

Dental Information

Do you have a specific dental problem? Describe: _____
 Do you have dental examinations on a routine basis? _____ Date of last visit: _____
 Do you brush and floss on a routine basis? _____
 Do you think you have active decay or gum disease? _____
 Do your gums ever bleed? _____
 Do you like your smile? Why? _____
 Does food catch between your teeth? Do you have any loose teeth? _____
 Do you want to keep your remaining teeth? _____
 Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____
 Have your past experiences in the dental office always been positive? _____
 Do you smoke chew vape use Marijuana use Nicotine Patch consume alcohol
 Are there any sores or growths in your mouth? _____
 Name of previous dentist? (Optional) _____
 Date of your last full mouth x-rays? _____

Health Information

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

<input type="checkbox"/> Heart Trouble /Disease	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis A or B	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Fainting or Dizziness
<input type="checkbox"/> Angina / Chest Pain	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Radiation Tx for cancer	<input type="checkbox"/> Thyroid/Parathyroid Disease	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Heart Attack / Failure	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Arthritis / Gout	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Hemophilia(Bleeding)	<input type="checkbox"/> Stomach/Intestinal Disease	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Nervousness / Anxiety
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Pain in jaw joint	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Recent weight loss	<input type="checkbox"/> Cortisone medications	<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Swelling of limbs	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Allergies to Medications
<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Allergies Pollen / Dust
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Frequent cough	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> AIDS / HIV +	<input type="checkbox"/> Hives or Rash
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma / Hay Fever	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Taking Medications
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Cold sores/fever blisters	

• Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____

• Have you been ever been hospitalized or had a major operation? Yes No Injury to head or neck? 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: _____

• **Are you taking any medications, pills or drugs? List?** _____

• **Are you allergic to any medications or substances? Please check below:**
 Aspirin Penicillin Codeine Acrylic Metal Latex rubber Other _____

• **FOR WOMEN: Are you pregnant or trying to get pregnant?** Yes No

• Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

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 doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ **Date:** _____

Spouse, Parent, Guardian Information or Emergency Contact

The following is for: the patient's spouse the patient's parent the patient's guardian Emergency Contact

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ **Birth Date:** _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Home Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

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: _____

Referral Information

Whom may we thank for referring you to our practice? Website Insurance website Yellow Pages Drive by
 Facebook Catholic Sun Newspaper School Work Postcard in the mail Other: _____
 Another patient: Name of person or office referring you to our practice: _____

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.

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 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 patients 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 1½% 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 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.

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 authorized the Dentist and Staff to perform an examination, which may include x-rays. If diagnosed with prophylaxis (regular cleaning), I authorize to have the procedure done as per the treatment plan presented.

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 & Guarantor of payment/responsible party