## PATIENT INFORMATION

Patient Name: ______________________________ Date: ______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

**BIRTH DATE:** ______________________ Social Security #: ______________________

Phone (Home:) ______________ (Work:) ______________ Ext: ________ (Cell:) ______________

Best time to call: ______________ E-Mail: ______________ OK to Receive Text Messages? ________

Address: ______________________________
Street Apt #

______________________________
City State Zip

## EMPLOYMENT INFORMATION

The is for ☐ the patient ☐ person responsible for payment

Employer Name ______________________________ Occupation: ______________

Address: ______________________________
Street City State Zip

## INSURANCE INFORMATION

**PRIMARY (Applies to person who is the Employee or "Owner" of the policy.)**

Name of Insured: ______________________________ Is Insured a patient? ☐ Yes ☐ No

Insurance Company: ______________________________

Insured's Birth Date: ______________ ID# ______________ Group # ______________

Insured's Address: ______________________________
Street City State Zip

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name, Address and Phone Number: ______________________________

______________________________

**SECONDARY (Applies to person who is the Employee or "Owner" of the policy.)**

Name of Insured: ______________________________ Is Insured a patient? ☐ Yes ☐ No

Insurance Company: ______________________________

Insured's Birth Date: ______________ ID# ______________ Group # ______________

Insured's Address: ______________________________
Street City State Zip

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name, Address and Phone Number: ______________________________

______________________________

## REFERRAL INFORMATION

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ______________

Name of person or office referring you to our practice: ____________________________________________________________

## SPOUSE OR RESPONSIBLE PARTY INFORMATION

The is for ☐ the patient's spouse ☐ person responsible for payment

Name ____________________________________________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: ______________________

Social Security #: ______________________________ Birth Date: ______________________

Phone (Home:) ______________________ (Work:) ______________________ Ext: __________ (Cell:) ______________

Address: ____________________________________________________________

Street Apt #

____________________________________________________________

City State Zip

## HIPAA PRIVACY NOTICE

**I have read the HIPPA Privacy Notice that is placed next to the sign-in sheet on the counter**.

Print Name: ______________________ Signature: ______________________________________ Date: _________

## 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 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 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 the insurance company.

*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 have read the above conditions of treatment and payment and agree to their content.________

______________________________ ______________________ __________

Signature of Patient, Parent, or Guardian Relationship to Patient Date

______________________________ ______________________ __________

Signature of Guarantor of Payment/Responsible Party Relationship to Patient Date

PATIENT NAME: ____________________________________________________________ Date_________________

# Health Questionnaire

Date of Last Dental Visit: ______________________ Reason for this visit: ______________________________________________

| Are you Allergic, or have you reacted adversely, to any of the following? | YES | NO | During the past 12 months, have you taken any of the following? | YES | NO |
|---|---|---|---|---|---|
| Local anesthetics ("Novocain") | | | Antibiotics or sulfa drugs | | |
| Penicillin | | | Anticoagulants (e.g., Coumadin) | | |
| Sulpha | | | High blood pressure medicine | | |
| Codeine | | | Tranquilizers | | |
| Other Antibiotics: | | | Insulin, Orinase, or similar drug | | |
| Barbiturates, sedatives, or sleeping pills | | | Aspirin | | |
| Aspirin, Acetaminophen, or Ibuprofen | | | Digitalis or drugs for heart trouble | | |
| Codeine, Demerol, or other narcotics | | | Nitroglycerin | | |
| Reaction to metals | | | Cortisone (steroids) | | |
| Latex or rubber dam | | | Natural remedies | | |
| Other | | | Nonprescription drug/supplements | | |
| | | | Other | | |
| **Have you ever had any of the following?** | **YES** | **NO** | **Have you ever had any of the following?** | **YES** | **NO** |
| AIDS | | | High Blood Pressure | | |
| Anemia | | | HIV | | |
| Arthritis | | | Jaundice | | |
| Artificial Joints | | | Kidney Disease | | |
| Blood Disease (Type ________________) | | | Liver Disease | | |
| Cancer (What Kind? _________________) | | | Mental Disorders | | |
| Diabetes | | | Nervous Disorder | | |
| Dizziness | | | Osteoporosis | | |
| Epilepsy | | | Pacemaker | | |
| Excessive Bleeding | | | Radiation Treatment | | |
| Fainting | | | Respiratory Problems | | |
| Glaucoma | | | Rheumatic Fever | | |
| Growths | | | Rheumatism | | |
| Hay Fever | | | Sinus Problems | | |
| Head Injuries | | | Stroke | | |
| Heart Attack | | | Tuberculosis | | |
| → If "YES", Date: | | | Tumors | | |
| Heart Murmur | | | Ulcers | | |
| Hepatitis | | | Venereal Disease | | |

| WOMEN | YES | NO |
|---|---|---|
| Are you taking contraceptives or other hormones | | |
| Are you pregnant? If so, expected delivery date: | | |
| Are you nursing? | | |
| Have you reached menopause? | | |
| If so, do you have any symptoms? | | |

PATIENT NAME: ______________________________________________ Date________________

| DENTAL HEALTH HISTORY | | | |
|---|---|---|---|
| How often do you brush? | | How often do you floss? | |

| Please indicate your answer… | YES | NO | Please indicate your answer… | YES | NO |
|---|---|---|---|---|---|
| Do you have pain in the face, cheeks, jaws, joints, throat, or temples? | | | Are you apprehensive about dental treatment? | | |
| Do you clench or grind your jaws frequently? | | | Do your gag easily? | | |
| Are you a habitual gum chewer or pipe smoker? | | | Does food catch between your teeth? | | |
| Have you had problems with previous dental treatment? | | | Do you chew on only one side of your mouth? | | |
| Do you wear dentures? | | | Do your gums bleed easily? | | |
| Do you have difficulty in chewing your food? | | | Do your gums feel swollen or tender? | | |
| Do you avoid brushing any part of your mouth because of pain? | | | Are your teeth sensitive? | | |
| Do your gums bleed when you floss? | | | Do you take fluoride supplements? | | |
| Have you ever noticed slow-healing sores in or about your mouth? | | | Are you dissatisfied with the appearance of your teeth? | | |
| Do you feel twinges of pain when your teeth come in contact with: | | | Do you prefer to save your teeth? | | |
| → Hot foods or liquids? | | | Do you want complete dental care? | | |
| → Cold foods or liquids? | | | | | |
| → Sours? | | | | | |
| → Sweets? | | | | | |

## PLEASE LIST ALL CURRENT MEDICATIONS:

| Medication | Strength | How Often Do you Take? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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.

______________________________________________ Date: ______________________
Signature