Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: «_____ Family Status:_____

Social Security #: *«SS»*_____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell)_____

Email:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Answer **ALL** questions by **circling** either **YES** or **NO** and fill in all blank spaces where indicated. Answers to the following questions are for our records only and are confidential.

- Have you ever had any complications following a dental treatment? **Yes** **No**
  If yes, please explain:_____
- Are you now under the care of a physician? **Yes** **No**
  If so, what condition is being treated and who is the provider of this treatment?
  _____
- Have you had any serious illness or operation? **Yes** **No**
  If so, what was the illness or operation?_____
- Do you need to take an antibiotic prior to dental appointments? **Yes** **No**
  If so, for what reason:_____
- Do you have any health problems that need further clarification? **Yes** **No**
  If yes, please explain:_____

Do you have or have you ever had any of the following

Anemia	**Yes**	**No**	High Blood Pressure	**Yes**	**No**
Arthritis	**Yes**	**No**	HIV/AIDS	**Yes**	**No**
Artificial Joints	**Yes**	**No**	Kidney problems	**Yes**	**No**
Date:_____			Liver Disease	**Yes**	**No**
Asthma	**Yes**	**No**	Mental Disorders	**Yes**	**No**
Autoimmune Disease	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**
Blood Disease	**Yes**	**No**	Nervous Disorders	**Yes**	**No**
Cancer	**Yes**	**No**	Pacemaker	**Yes**	**No**
Chronic Dry Mouth	**Yes**	**No**	Radiation treatment	**Yes**	**No**
Dementia/Alzheimers	**Yes**	**No**	Respiratory problems	**Yes**	**No**
Diabetes	**Yes**	**No**	Rheumatic Fever	**Yes**	**No**
Epilepsy	**Yes**	**No**	Seizures	**Yes**	**No**
Excessive Bleeding	**Yes**	**No**	Sinus problems	**Yes**	**No**
Fainting Spells	**Yes**	**No**	Stomach problems	**Yes**	**No**
Glaucoma	**Yes**	**No**	Stroke	**Yes**	**No**
Growths	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Head Injuries	**Yes**	**No**	Ulcers	**Yes**	**No**
Hepatitis	**Yes**	**No**	Venereal Disease	**Yes**	**No**

Cardiovascular Disease (heart trouble/surgery, heart attack, angina, stroke, high blood pressure, heart murmur) **Yes** **No** Date of occurrence:_____

Are you pregnant? **Yes** **No**
If yes, what is your due date?_____

Have you had abnormal bleeding associated with previous extractions, surgery or trauma?
Yes **No**
Do you bruise easily? **Yes** **No**
Have you ever required a blood transfusion? **Yes** **No**

Do you have any blood disorder such as anemia or sickle cell anemia? **Yes** **No**

Have you had surgery or radiation treatment for a tumor, cancer or other condition of your head or neck?
Yes **No**

Please list ALL current prescription and over the counter medications:_____
_____
_____

Are you taking any of the following?
Antibiotics or sulfa drugs **Yes** **No**
Anticoagulants (blood thinners) **Yes** **No**
Medicine for high blood pressure **Yes** **No**
Cortisone (steroids) (including prednisone) **Yes** **No**
Tranquilizers **Yes** **No**
Daily Aspirin therapy **Yes** **No**
Insulin or similar drug for diabetes **Yes** **No**
Digitalis or drugs for heart troubles **Yes** **No**
Nitroglycerin **Yes** **No**
Antihistamine **Yes** **No**
Oral birth control drug or hormonal therapy **Yes** **No**
Medicines for osteoporosis **Yes** **No**
Other_____

Are you allergic or have you reacted adversely to:
Local anesthetics (lidocaine, novocaine) **Yes** **No**
Penicillin **Yes** **No**
Other antibiotics (please specify)_____ **Yes** **No**
Epinephrine **Yes** **No**
Sulfa drugs **Yes** **No**
Aspirin **Yes** **No**
Codeine or other narcotics **Yes** **No**
Latex **Yes** **No**
Other_____

Do you have any disease, condition, or problem not listed above? **Yes** **No**
If yes, please explain:_____

Tobacco use: (Circle one) Current Former Never

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 of patient, parent or guardian

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

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

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party