PATIENT INFORMATION

TODAY'S DATE ________________

PATIENT'S NAME____ AGE _____ DOB_____________ MALE _____FEMALE _____
LAST FIRST MI

IF PATIENT IS A MINOR, GIVE NAME OF PARENT OR LEGAL GUARDIAN _____________________________ RELATIONSHIP _____________

RESIDENCE ADDRESS____ FOR HOW LONG__________ OWN____ RENT______
STREET CITY ZIP

PATIENT IS: __MARRIED __SINGLE __DIVORCED __SEPARATED __WIDOWED __MINOR

EMAIL ______________________________________

DRIVER'S LICENSE NO. _______________ SOCIAL SECURITY NO._________________

RES. PHONE _________________________________

EMPLOYED BY __________________________________ HOW LONG ______________

CELL PHONE _________________________________

BUS. PHONE _________________________________

BUSINESS ADDRESS ____
STREET CITY ZIP

SPOUSE'S NAME __________________________________ EMPLOYED BY ___________________________________ HOW LONG _________

FORMER DENTIST ___________________________________ REASON FOR LEAVING ____

PURPOSE OF APPOINTMENT ____

WHOM MAY WE THANK FOR REFERRING YOU?_________________________________PHARMACY__________________________________

EMERCENTY CONTACT:____PHONE____________________________________

PHYSICIAN NAME____PHONE____________________________________

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT ____RELATIONSHIP TO PATIENT ________________

ADDRESS ____
STREET CITY ZIP

RES. PHONE ________________________________ CELL PHONE __________________________ BUS. PHONE ___________________________

NAME OF INSURANCE CO. ___________________________________ INSURANCE PHONE __________________________GROUP # __________

SUBSCRIBER _____________________________ DOB ______________ SS#_____________________ RELATIONSHIP TO PATIENT _________

NAME OF SECONDARY INSURANCE CO. ___________________________ INSURANCE PHONE ________________________ GROUP # ________

SUBSCRIBER________________________ DOB _______________ SS#_____________________ RELATIONSHIP TO PATIENT _____________

TERMS & CONDITIONS

AS A CONDITION OF TREATMENT BY THIS OFFICE, I UNDERSTAND FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE. THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM THE PATIENTS FOR THE COST 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 SERVICE PERFORMED WITHOUT PRIOR FINANCIAL ARRANGEMENTS, MUST BE PAID FOR AT THE TIMES SERVICES ARE PERFORMED.

I UNDERSTAND THAT DENTAL SERVICES, FURNISHED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY REPONSIBLE FOR PAYMENT OF ALL DENTAL SERVICES. IF I CARRY INSURANCE, I UNDERSTAND THAT THIS OFFICE WILL HELP PREPARE MY INSURANCE FORMS TO ASSIST IN MAKING COLLECTIONS FROM INSURANCE COMPANIES AND WILL CREDIT SUCH COLLECTIONS TO MY ACCOUNT. HOWEVER, THIS OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT CHARGES WILL BE PAID BY AN INSURANCE COMPANY.

ASSIGNMENT OF INSURANCE: I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO MY DENTIST BENEFITS ACCRUING TO ME UNDER MY POLICY. A SERVICE CHARGE OF 1 1/2 % PER MONTH (18% PER ANNUM) (BUT IN NO EVENT MORE THAN THE MAXIMUM RATE PERMISSIBLE UNDER STATE LAW) WILL BE CHARGED ON THE UNPAID PRINCIPAL BALANCE ON ALL ACCOUNTS NOT PAID WITHIN 60 DAYS OF TREATMENT DATE.

I UNDERSTAND THAT THE FEE ESTIMATE LISTED FOR THIS DENTAL CASE CAN ONLY BE EXTENDED FOR A PERIOD OF SIX MONTHS FRO THE DATE OF THE PATIENT'S EXAMINATION.

IN CONDERATION OF THE PROFESSIONAL SERVICES RENDERED TO ME, OR AT MY REQUEST, BY THE DOCTOR AND/ OR HIS STAFF, I AGREE TO PAY, THEREFORE, THE REASONALBE VALUE OF SAID SERVICES SHALL NOT CONSTITUTE A WAIVER OF ANY FURTHER TERM OR CONDITION. I FURTHER AGREE THAT IN THE EVENT THAT EITHER THIS OFFICE OR I INSTITUTE ANY LEGAL PROCEEDINGS WITH RESPECT TO AMOUNTS OWED BY ME FOR SERVICES RENDERED, THE PREVALLING PARTY IN SUCH PROCEEDINGS SHALL BE ENTITTLED TO RECOVER ALL COST INCURRED INCLUDING REASONABLE ATTORNEY'S AND/OR COLLECTION FEES.

I GRANT MY PERMISSION TO YOU, OR YOUR ASSIGNS, 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 AGREE TO THEIR CONTENT.

SIGNED ____ DATE ____________

PLEASE FILL OUT BOTH SIDES OF FORM

HEALTH QUESTIONAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to our dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/ or circle Yes or No where applicable.

Medical History

- Are your in good health?..Yes No
- Date of last physical exam……………………………………………………………………………………...Yes No
- Are you under the care of a physician?..Yes No
  If so, what is the condition being treated ____
- Have you ever had any serious illness or operation?..Yes No
  If so what was the illness or operation?____
- Have you ever been hospitalized?...Yes No
  If so, what for? ____
- Are you taking any __medications __ drugs or __ herbs……………………………………………………...Yes No
  If so, what? ____
- Are you using any recreational drugs (marijuana, cocaine, etc.)? ……………………………………………..Yes No
- Have you ever been told to pre-medicated with antibiotics for all your dental treatment……………...…………………….Yes No
- Are you allergic to any drugs or materials? __penicillin, __tetracycline, __sulfa drugs, __aspirin, __ codeine, __ latex, __other ……….Yes No
  If other explain ____
- Do you have or have you had any of the following: (Please circle **Y** for yes and **N** for no.- answer each question)

Y N Anemia	Y N Cerebral Palsy	Y N Headaches	Y N Mental Disorder	Y N Stomach Ulcers
Y N Arthritis	Y N Chemotherapy	Y N Hemophilia	Y N Mitral Valve Prolapse	Y N Sickle Cell Disease
Y N Angina Pectoris	Y N Cortisone Medicine	Y N Head Injuries	Y N Nervous Disorders	Y N Sleep Apnea
Y N Allergies or Hives	Y N Congenital Heart Lesions	Y N Heart Failure	Y N Osteoporosis	Y N Snoring
Y N Asthma	Y N Diabetes	Y N Heart Murmur	Y N Psychiatric Treatment	Y N Tonsillitis
Y N Artificial Prosthesis	Y N Drug Addiction	Y N Heart Ailments	Y N Pain in Jaw or Joints	Y N Thyroid disease
Y N Allergies to Metals	Y N Difficulty Swallowing	Y N Heart Attack	Y N Rheumatism	Y N Tuberculosis (TB)
Y N Aids	Y N Emphysema	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Tumors or Growths
Y N Bruise Easily	Y N Excessive Bleeding	Y N HIV Related Complex	Y N Respiratory Disease	Y N TMJ
Y N Blood Disease	Y N Epilepsy or Seizures	Y N Hepatitis or jaundice	Y N Radiation Treatment	Y N Ulcers
Y N Blood Transfusion	Y N Fainting Spells	Y N Implants	Y N Stroke	Y N Venereal Disease
Y N Cancer	Y N Glaucoma	Y N Joint Replacement	Y N Seizures	Y N Other
Y N Cold Sores	Y N Herpes	Y N Kidney Disease	Y N Scarlet Fever	____________________
Y N Chicken Pox	Y N Hay Fever	Y N Liver Disease	Y N Sinus Trouble	____________________

- Do you have any disease, condition or problem not listed that you think we should know about? …………………………..Yes No
  If so, what? ____
- Do you wear a cardiac pacemaker, or have you had heart surgery? …………………………………………………………Yes No
- Do you smoke? If yes how much? __Cigarettes __ Cigars Packs per day?______________ …………………………..Yes No
- Have you ever taken the drugs _Fen-Phen, __ Redux or any, __Diet Drug …………………………………………………Yes No
- Are you pregnant? If so how many months? ………………………………………..……………………..…………Yes No
- Do you take any birth control medication or hormones?..Yes No

Dental History

- Have you ever had local anesthetic (Novocaine, etc.)? …………………..……………………………………………Yes No
- Have you ever had any unfavorable reaction from a local anesthetic? …………………………………………………..Yes No
- Have you had any serious trouble associated with any previous dental treatment?...Yes No
  If yes, explain. ____
- How long since your last full mouth x-rays? _______________ last dental cleaning ______________________________
- Does dental treatment make you nervous ______________________________
- Would you desire to be pre-sedated __________________________________

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Date __________Patients Signature (or responsible party if under 18) ____

Office Use

Reviewed by ____ Lic #____________________ Date:_______________________