Patient Information

Name:	Occupation:
Prefers:	Employer:
Address:	Work #:
Home Ph#:	Emergency Contact:
Cell Ph#:	Relationship:
E-mail Address:	Em. Contact Ph#:
Date of Birth:	Em. Contact Cell #:
Social Security #:	

Physician name:	Physician Phone:
Pharmacy:	Pharmacy Phone:

For Office Use Only

Medical Alerts:

What is the reason for your visit today:

When was your last dental visit?

What was done at this visit?

How often do you see your dentist?

Sex:

Height:

Weight:

If female please answer the following: Y N

Are you taking birth control pills? ☐☐

Are you pregnant? ☐☐ If yes, how many weeks?

Are you nursing? ☐☐

Please answer the following:

Do you use tobacco? ☐☐

Conditions	Y	N	Conditions	Y	N	Conditions	Y	N
Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Stroke	☐	☐
Drug or Alcohol Abuse	☐	☐	HIV+ AIDS	☐	☐	Thyroid Problems	☐	☐
Allergies	☐	☐	Heart Attack	☐	☐	Tuberculosis	☐	☐
Anemia	☐	☐	Heart Murmur	☐	☐	Ulcers	☐	☐
Angina Pectoris	☐	☐	Heart Surgery	☐	☐			
Arthritis	☐	☐	Hemophilia	☐	☐	**Allergies**	Y	N
Artificial Joints/Bones	☐	☐	Hepatitis A,B,C	☐	☐	Aspirin	☐	☐
Artificial Heart Valve	☐	☐	High Blood Pressure	☐	☐	Codeine	☐	☐
Asthma	☐	☐	Kidney Problems	☐	☐	Dental Anesthetics	☐	☐
Blood Transfusion	☐	☐	Liver Disease/Jaundice	☐	☐	Erythromycin	☐	☐
Cancer-Chemotherapy	☐	☐	Low Blood Pressure	☐	☐	Jewelry	☐	☐
Cervical Spinal Fusion	☐	☐	Mitral Valve Prolapse	☐	☐	Latex	☐	☐
Congenital Heart Defect	☐	☐	Pace Maker	☐	☐	Metals	☐	☐
Cosmetic Surgery	☐	☐	Pneumocystis	☐	☐	Penicillin	☐	☐
Diabetes	☐	☐	Psychiatric Problems	☐	☐	Tetracycline	☐	☐
Difficulty Breathing	☐	☐	Radiation Therapy	☐	☐	Sulfa	☐	☐
Emphysema	☐	☐	Rheumatic Fever	☐	☐	Other:		
Epilepsy	☐	☐	Seizures	☐	☐			
Fainting Spells	☐	☐	Shingles	☐	☐			
Fever Blisters	☐	☐	Sinus Problems	☐	☐			
Frequent Headaches	☐	☐						
	☐	☐						

Are you currently taking any medications?

Please list:

Referral Information

Whom may we thank for referring you to our practice? ☐Another Patient ☐Dental Office
☐Yellow Pages ☐School ☐Work ☐Other
Name of person or office referring you to our practice:

Do you want to have your treatment designed around: Your Optimal health_____
Dental insurance limitations____

Please rank the following, in order of importance: ____Quality, ____ Cost, ____Convenience

Dental Insurance Information

Self insured? YES NO
Insured name:_____ Is insured a patient? YES NO
Insured's DOB:_____ ID#_____ G#_____
Insured's Address:_____
Insured's Employer Name: _____
Address:_____
Patient's relationship to insured: SELF SPOUSE CHILD OTHER
Insurance Plan Name and Address:_____
_____

Consent for Services

All emergency dental services, or any dental services performed must be paid for at the time of treatment. We accept VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS/CHECK/CASH.

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 assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days 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 for all services to said Doctor, or his assignee, at the time said services are rendered. 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:_____

I allow my doctor to be consulted if necessary:

Signed:_____ Date:_____

I allow my photograph to be used or displayed for educational or promotional purposes:

Signed:_____ Date:_____