

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____

Last, First MI (Preferred Name)

Gender: _____ Family Status: _____ Social Security #: _____ Birth Date: _____

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

(Pager): _____ (Other): _____ Best time to call: _____

E-Mail Address: _____

Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S

Address: _____

Street

Apartment #

City

State

Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

AIDS

Allergies _____

Anemia

Arthritis

Artificial Joints

Asthma

Blood Disease

Cancer

Diabetes

Dizziness

Epilepsy

Excessive Bleeding

Fainting

Glaucoma

Growths

Hay Fever

Head Injuries

Heart Disease

Heart Murmur

Hepatitis

High Blood Pressure

Jaundice

Kidney Disease

Liver Disease

Mental Disorders

Nervous Disorders

Pacemaker

Pregnancy

Due date: _____

Radiation Treatment

Respiratory Problems

Rheumatic Fever

Rheumatism

Sinus Problems

Stomach Problems

Stroke

Tuberculosis

Tumors

Ulcers

Venereal Disease

Codeine Allergy

Penicillin Allergy

OTHER:

- _____

- _____

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? 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: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Please List Medications: _____

**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: _____

Emergency Contact Information

Name: _____

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

Address: _____

Street

Apartment #

City

State

Zip Code

Referral Information

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

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

Dental Office Yellow Pages Web Site School Work Other _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City,

State

Zip Code

Phone

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

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: _____

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

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. 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.

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 Date: _____ Relationship to Patient: _____

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