Patient Information

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

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

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

Address: _____
Street Apartment #

_____

E-mail: _____

If you have dental insurance, please present your insurance card to receptionist.

Health Information

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Bisphosphonates, Oral or IV
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drugs (recreational)
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due Date _____
- ☐ Radiation treatment
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Steroids taken in last 2 years
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgery
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfur Allergy
- ☐ Latex Allergy
- ☐ Other Medication Allergy:
  _____
  _____
  _____
- ☐ Other Allergies?
  _____
  _____

PLEASE LIST ALL MEDICATION(s):

_____
_____
_____

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: _____

Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Online Search ☐ Newspaper ☐ School ☐ Work ☐ Other _____

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

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 at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished can be charged directly to the patient and that he or she is personally responsible for payment of all dental services on the day services are rendered. 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 finance charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. Unpaid balances beyond 60 days will accrue interest at the rate listed above. Patients with insurance will begin to accrue interest 30 days after insurance payment has been received. **ACCOUNTS OVER 90 DAYS WILL BE SENT TO COLLECTIONS.** In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee equal to 40% of the unpaid balance. In the event of a lawsuit to collect an unpaid balance, the undersigned further agrees to pay court cost and attorney fees.

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 use any known contact information and method to discuss matters related to this form, including but not limited to, collection of a debt.

Dental Appointment Agreement

It is important for patients to keep their dental appointments, because broken appointments result in lost time that could have been used to treat other patients.

Rescheduling Appointments

The dental staff understands that sometimes situations arise that require rescheduling of your appointment. If you need to reschedule, please call our office as soon as you know that you will not be able to keep the appointment, at least 24 hours before the appointment time.

Broken Appointments

If you miss a scheduled appointment or cancel it at the last minute, a broken appointment will be recorded in your dental chart. If you are more than ten minutes late for an appointment, a broken appointment will also be recorded, and you may have to be rescheduled if there is not enough time to complete your procedure. It is not fair to keep other patients waiting because one showed up late.

If you have two broken appointments during a six month period, you will only be rescheduled by prepaying for the 3rd appointment via a **NON-REFUNDABLE** rescheduling fee equal to that of the treatment to be provided at that scheduled appointment. This fee will be applied to treatment costs only if you present and keep the pre-paid appointment. If you do not present and keep the third appointment, making the sum total of missed appointments within a 6 month period equal to three, you will be dismissed as a patient from this dental practice, and the rescheduling fee that was paid prior to scheduling the third appointment will be forfeited by you and **NOT** returned to you. However, you will be eligible for emergency dental care for thirty days only, after the date of the third broken appointment.

I have read, understand and agree to all of the above and 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.

Patient Name (Please Print) Date

Patient or Guardian Signature