Patient Information

First Name: _____ MI: ____ Last Name: _____ Nickname: _____

Date of Birth: _____ Please Circle: Male Female SS#: _____

Cell Phone: _____ Work Phone: _____ Ext._____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred method of contact (please circle): Cell Phone Home Phone Work Phone E-Mail Text Message

Employer: _____ State ID/Driver's License #: _____

E-Mail: _____ How did you hear about our office: _____

Health History

Please check yes or no on all listed:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV			Heart Disease			Rheumatic Fever		
Alcoholism			Heart Surgery			Scarlet Fever		
Allergies			Heart Valve/Murmur			Sinus Problems		
Anemia			Hepatitis			Stent(s): -When?		
Arthritis			High Blood Pressure			Stroke		
Asthma			HPV			Thyroid Disease		
Blood Thinners:			Joint Replacement: -When?			Tuberculosis		
-Aspirin only			Kidney Disease			Tumors or growths		
-Prescription			Latex Allergy			Ulcers		
Cancer -Type:			Liver Disease			Use of Tobacco Products		
Chemical Dependency			Lupus			Other:		
Chest Pain			Low Blood Pressure					
Circulatory Problems			Mitral Valve Prolapse					
Diabetes			Neck/Back Problems					
Epilepsy			Nervous Disorder					
Excessive Bleeding			Pacemaker					
Fainting Spells			Psychiatric Care					
Head Injury			Radiation Treatment					
Hearing Impaired			Respiratory Problems					

List all medications you are taking including non-prescription meds: _____

_____

List all medications you are allergic to: _____

Are you in good health (please circle) Yes No Date of last medical exam: _____

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Name of Physician: _____ Phone: _____ Seeing MD for: _____

Have you ever been hospitalized? (Please circle): Yes No If yes, why? _____ When? _____

Have you had a transplant operation that has depressed your immune system? (Please circle): Yes No

Are you currently or have you ever taken bisphosphonates (i.e. Fosamax or Actonel for osteoporosis, chemotherapy, etc.)? (Please circle): Yes No

For Women Only: Are you taking birth control pills? (Please circle) Yes No Are you nursing? Yes No

Are you pregnant? Yes, Due date _____ No Is there a possibility of pregnancy? Yes No

Dental History

Date of last dental visit: _____ Name of previous dentist: _____

Do your gums bleed when brushing or flossing? Yes No

Have you or a family member ever been treated for periodontal disease? Yes No Unsure

Have you ever had complications from an extraction? Yes No

Are you prone to frequent headaches? Yes No

Do you have jaw popping or clicking? Yes No

Do you clench or grind your teeth? Yes No

Do you have sores, blisters or swelling on your gums, lips or cheeks? Yes No

Have you had orthodontic treatment (braces or clear aligners)? Yes No

Do you snore? Yes No

Do you have problems with bad breath? Yes No

Are your teeth sensitive to hot, cold or pressure? Yes No

If you could change something about your smile, what would it be? (Circle all that apply.)

Whiter	Straighter	Close spaces	Replace metal fillings	Repair chipped/broken teeth
Replace missing teeth	Show less gums	Replace crowns/fillings that don't match	Replace denture/partial	Better fitting denture/partial

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient/Guardian: I hereby consent to treatment including the use of any anesthetics, sedatives or x-rays, as may be deemed necessary by the dentist.

Signature: _____ Date: _____

PAYMENT ARRANGEMENT FORM

NAME OF PATIENT (please print): _____

Payment Agreement:
I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice. I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

RESPONSIBLE PARTY (if someone other than the patient is responsible for patient's finances, please complete):

Full Name: _____ DOB: _____ SSN#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Work phone: _____ Ext. _____

Employer: _____

INSURANCE INFORMATION:

Primary Insurance:

Insurance Co: _____ Address: _____ Phone Number: _____

Name of Insured/Policy holder: _____ Relationship to patient: _____

ID Number: _____ Group/Plan Number: _____ Insured/Policy holder's employer: _____

Secondary Insurance:

Insurance Co: _____ Address: _____ Phone Number: _____

Name of Insured/Policy holder: _____ Relationship to patient: _____

ID Number: _____ Group/Plan Number: _____ Insured/Policy holder's employer: _____

Signature of Responsible Party: _____ **Date:** _____