Patient Information

Patient Name: ____ Date:__________ ☐ Male ☐ Female
Last First MI

Social Security / ID #: _______________________ Birth Date:_______________ E-mail ________________

Phone (Home): ______________ (Work): ______________ Ext:______ Cell Phone: _______________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ________________ Reason for this visit:________________________________

Has your child ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies
____
____
☐ Anemia
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Latex Allergy
☐ Liver Disease
☐ Mental Disorders
☐ Stomach Problems
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Tumors
☐ Ulcers
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _______________
☐ _______________

- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Has your child ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Is your child now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Physician: ____ Phone:________________
- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____
- Please list all medications your child is currently taking:_______________________________________
- Are there any Social, Cultural or Religious beliefs that may inhibit treatment? ☐ Yes ☐ No
  If yes, please explain:____

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 child's health, I will inform the doctors at the next appointment without fail.

____ Date:____________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other________________

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

Parental Guardian Information

Are there any custody restrictions that this office needs to be aware of?____

Please provide names of individuals that you permit this office to release information to:____

Parenting Adults Information

Name: ____

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): __________ (Work): __________ Ext:______ Cell Phone: __________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

Employer Name: ____________________ Occupation: ____________________

Address: ____

Street City State Zip Code

Parenting Adults Information

Name: ____

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): __________ (Work): __________ Ext:______ Cell Phone: __________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

Employer Name: ____________________ Occupation: ____________________

Address: ____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________________

Insurance Plan Name and Address & Phone: ______________________________

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HIPPA Compliancy

This office follows all current HIPPA procedures and guidelines to protect your health information. A copy of the full article is available for you at the front desk if needed. By completing and signing this form you grant this office the authorization to use your protected health information in a manner consistent with current guidelines. INTL _________

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 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.

A service charge of 1½% per month (18% per annum) or $5.00 (whichever is greater) on the unpaid balance will be charged on all accounts, unless previously written financial arrangements are satisfied. The office reserves the right to charge $25.00 for all missed or cancelled appointments without a 24-hour advanced notice. There will be a $25.00 fee for all returned checks.

I understand that the fee estimate listed for this dental care can only be extended for a period of three 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. 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 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: __________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: __________

Signature of guarantor of payment/responsible party