Last Name_____ First_____ Home Phone #( )_____

Address_____ Business Phone #( )_____

Cell Phone # ( )_____

City _____ State_____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth __/__/__ Sex M F Height _____ Weight_____ Single____ Married____

Name of Spouse _____ Closest Relative_____ Phone #( )_____

If you are completing this form for another person, what is your relationship to that person?_____

Referred by_____

For the following questions , *circle yes or no*, which ever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year?..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician?..... Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
   _____
   _____
6. Have you had any serious illness, operation or been hospitalized in the past 5 years?..... Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine?..... Yes No
   If so, what medicine(s) are you taking? _____
8. Do you have or had any of the following diseases or problems?

a) Damaged heart valves or artificial heart valves, including heart murmur or rheumatic disease Yes No

b) Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... Yes No

1. Do you have chest pain upon exertion?..... Yes No
2. Are you ever short of breath after mild exercise or when lying down? ..... Yes No
3. Do your ankles swell? ..... Yes No
4. Do you have inborn heart defects? ..... Yes No
5. Do you have a cardiac pacemaker? ..... Yes No

c) Allergy ..... Yes No

d) Sinus trouble ..... Yes No

e) Asthma or hay fever ..... Yes No

f) Fainting spells or seizures ..... Yes No

g) Persistent diarrhea or recent weight loss ..... Yes No

h) Diabetes ..... Yes No

i) Hepatitis, jaundice or liver disease ..... Yes No

j) AIDS or HIV infection ..... Yes No

k) Thyroid problems ..... Yes No

l) Respiratory problems, emphysema, bronchitis. Etc. ..... Yes No

m) Arthritis or painful swollen joints ..... Yes No

n) Stomach ulcer or hyperacidity ..... Yes No

o) Kidney trouble ..... Yes No

p) Tuberculosis ..... Yes No

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Telephone:_____

q) Persistent cough or cough that produces blood ..... Yes No
r) Persistent swollen glands or neck ..... Yes No
s) Low blood pressure ..... Yes No
t) Sexually transmitted disease ..... Yes No
u) Epilepsy or other neurological disease ..... Yes No
9. Have you had abnormal bleeding ..... Yes No
a) Have you ever required a blood transfusion? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you ever had any treatment for a tumor or growth? ..... Yes No
12. Are you allergic or have you had a reaction to:
a) Local anesthetics ..... Yes No
b) Penicillin or other antibiotics ..... Yes No
c) Sulfa drugs ..... Yes No
d) Barbiturates, sedatives, or sleeping pills ..... Yes No
e) Aspirin ..... Yes No
f) Iodine ..... Yes No
g) codeine or other narcotics ..... Yes No
h) Other _____
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
If so, explain _____
_____
14. Do you have any disease, condition or problem not listed above that I should know about? Yes No
If so, explain _____
_____
15. Are you wearing contact lenses? ..... Yes No
16. Are you wearing removable dental appliances? ..... Yes No

Women
17. Are you pregnant? ..... Yes No
18. Do you have any serious problems associated with your menstrual period? ..... Yes No
19. Are you nursing? ..... Yes No
20. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint _____
_____

Insurance Info: (Dental)
Type of Insurance _____
Wife/ Mother _____
Husband/ Father _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible foe any errors or omissions that I may have made in the completion of this form.

X _____
Signature of Patient

For completion by the dentist.
Comments on patient interview concerning medical history:
_____
_____
Significant findings from questionnaire or oral interview:
_____
_____
Dental management considerations:
_____

Date _____

_____
Signature of Dentist

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

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

Insured's Employer Name: _____

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: _____

Address: _____
Street City State Zip Code

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. 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) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 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