

# PATIENT INFORMATION

(This information is necessary for our files and will be considered **CONFIDENTIAL**)

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Patient's Birthday \_\_\_\_\_  Male  Female  
LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian \_\_\_\_\_

Relationship \_\_\_\_\_

Residence Address \_\_\_\_\_

For how long? \_\_\_\_\_  Own  Rent

Patient is:  Married  Single  Divorced  Separated  Widowed  Minor

E-mail \_\_\_\_\_

Driver's License No. \_\_\_\_\_ Social Security No. \_\_\_\_\_

Res. Phone (\_\_\_\_\_) \_\_\_\_\_

Bank \_\_\_\_\_ Account No. \_\_\_\_\_ How long? \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Employed by \_\_\_\_\_ How long? \_\_\_\_\_

Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Bus. Phone (\_\_\_\_\_) \_\_\_\_\_

STREET CITY ZIP

Soc. Sec. No. \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Occupation \_\_\_\_\_

Employed by \_\_\_\_\_ How long? \_\_\_\_\_

Bus. Phone (\_\_\_\_\_) \_\_\_\_\_

Business Address \_\_\_\_\_

Relationship \_\_\_\_\_

STREET CITY ZIP

Name of nearest relative not living with you \_\_\_\_\_

Res. Phone (\_\_\_\_\_) \_\_\_\_\_

Complete Address \_\_\_\_\_

I have no physician

STREET CITY ZIP

Name of Physician \_\_\_\_\_

(\_\_\_\_\_) TELEPHONE

Former Dentist \_\_\_\_\_

(\_\_\_\_\_) TELEPHONE

ADDRESS CITY

Why are you changing dentists? \_\_\_\_\_

Do you wish to speak to the doctor privately?  Yes  No

Purpose of Appointment \_\_\_\_\_

Is this office visit for Emergency Dental Care?  Yes  No If yes, explain: \_\_\_\_\_

School Children Attend \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

## FINANCIAL INFORMATION

Person responsible for this account \_\_\_\_\_ Relationship \_\_\_\_\_ (\_\_\_\_\_) TELEPHONE

Address \_\_\_\_\_ (\_\_\_\_\_) CELL PHONE

STREET CITY ZIP

PREFERENCE OF PAYMENT:  Cash on day of treatment  Visa No. \_\_\_\_\_ EXPIRATION DATE

State Aid No. \_\_\_\_\_  Mastercard No. \_\_\_\_\_ EXPIRATION DATE

Name of insurance company (primary insurance) \_\_\_\_\_

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

Name of insurance company (secondary insurance) \_\_\_\_\_

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

## TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

**Assignment of Insurance:** I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, 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 agree to their content:

Signed \_\_\_\_\_ Date \_\_\_\_\_



# HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? .....  Yes  No

## MEDICAL HISTORY

- Are you in good health? ..... Yes No
- Date of last physical examination ..... Yes No
- Are you now under the care of a physician? ..... Yes No  
If so, what is the condition being treated? .....
- Have you ever had any serious illness or operation? ..... Yes No  
If so, what illness or operation? .....
- Have you ever been hospitalized? ..... Yes No  
If so, what was the problem? .....
- Are you taking any  medications,  drugs or  herbs? ..... Yes No  
If so, what? ..... What dosage? .....
- Are you using any recreational drugs (marijuana, cocaine, etc.)?  Yes  No If so, what? .....
- Have you ever been pre medicated with antibiotics for your dental treatment? ..... Yes No
- Are you sensitive or allergic to any drugs or materials?  Penicillin;  Tetracycline;  Sulfa Drugs;  Aspirin;  Codeine;  Latex;  Other ..... Yes No  
If Other, what drugs? .....

10. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No - answer all conditions):

<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Other ..... ..... ..... ..... ..... ..... ..... ..... ..... .....
<input type="checkbox"/> Herpes	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Snoring	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Artificial Prosthesis	<input type="checkbox"/> Hepatitis or Jaundice	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Difficulty Swallowing	
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Congenital Heart Lesions	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Allergies to Metals	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Heart Ailments	<input type="checkbox"/> Tuberculosis (T.B.)	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> X-Ray or Cobalt Treatment	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Radiation Treatment of any kind	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhoea)	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS)	
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> HIV Related Complex	<input type="checkbox"/> TMJ (Temporomandibular Joint) Disorder	
<input type="checkbox"/> Headaches	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Tumors or Growths	<input type="checkbox"/> Respiratory Disease		
<input type="checkbox"/> Implant (s)	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Epilepsy or Seizures		

- Do you have any disease, condition or problem not listed that you think we should know about? ..... Yes No  
If so, what? .....
- Do you wear a cardiac pacemaker, or have you had heart surgery? ..... Yes No
- Do you smoke? If yes, how much?  Cigarettes  Cigars  Packs per day ..... Yes No
- Have you ever taken the drugs  Fen-Phen,  Redux,  Fosamax (Bisphosphonate),  Zometa,  Actonel,  Boniva,  Aredia,  Diet Drugs? ..... Yes No
- (Women) Are you pregnant? If so how many months? ..... Yes No
- (Women) Do you have any problems associated with your menstrual period? ..... Yes No
- (Women) Do you take any birth control medication or hormones? ..... Yes No

## DENTAL HISTORY

- Have you ever had a local anesthetic (Novocaine, etc.)? ..... Yes No
- Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
- Have you had any serious trouble associated with any previous dental treatment? ..... Yes No  
If so, explain? .....
- How long since your last full mouth X-Rays? ..... Weeks ..... Months ..... Years
- How long since your last dental treatment? ..... Weeks ..... Months ..... Years
- Does dental treatment make you nervous?  Slightly  Moderately  Extremely? ..... Yes No
- Would you desire to be pre-sedated? ..... Yes No

I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changes in any way.  Patient refused / was unable to sign because .....

I have received a copy of the **Dental Materials Fact Sheet** as required by law.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

**A** Date \_\_\_\_\_ Signature \_\_\_\_\_ Reviewed by \_\_\_\_\_ Lic. # \_\_\_\_\_ Date \_\_\_\_\_

**B UPDATE - Since your last visit (A):**

- Have you seen a medical doctor? ..... Yes No
- Have you had a change in your medication? ..... Yes No
- Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date \_\_\_\_\_ Signature \_\_\_\_\_

**C UPDATE - Since your last visit (B):**

- Have you seen a medical doctor? ..... Yes No
- Have you had a change in your medication? ..... Yes No
- Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date \_\_\_\_\_ Signature \_\_\_\_\_

REVIEWED BY		DO NOT WRITE IN THIS SPACE		
<b>A</b>		<b>A</b>	<b>B</b>	<b>C</b>
DATE	DATE			
<b>B</b>	B.P.	/	/	/
DATE	PULSE			
<b>C</b>	TEMP			
DATE	BY			

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

**CONSENT FOR TREATMENT:** I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_