Chart #: _____
FOR OFFICE USE ONLY

Patient Information

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

Email address _____ Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- AIDS/HIV Yes☐ No☐
- Allergies Yes☐ No☐
- Latex Allergies Yes☐ No☐
- Anemia Yes☐ No☐
- Arthritis Yes☐ No☐
- Codeine Allergy Yes☐ No☐
- Asthma Yes☐ No☐
- Blood Disease Yes☐ No☐
- Cancer Yes☐ No☐
- Diabetes Yes☐ No☐
- Dizziness Yes☐ No☐
- Epilepsy Yes☐ No☐
- Excessive Bleeding Yes☐ No☐
- History of Drug addiction Yes☐ No☐
- Fainting Yes☐ No☐
- Glaucoma Yes☐ No☐
- Growths Yes☐ No☐
- Hay Fever Yes☐ No☐
- Head Injuries Yes☐ No☐
- Artificial Heart Valves Yes☐ No☐
- Artificial Joints Yes☐ No☐
- Heart Disease Yes☐ No☐
- Heart Murmur (Mitral Valve Prolapse) Yes☐ No☐
- Hepatitis Yes☐ No☐
- High Blood Pressure Yes☐ No☐
- Jaundice Yes☐ No☐
- Kidney Disease Yes☐ No☐
- Liver Disease Yes☐ No☐
- Mental Disorders Yes☐ No☐
- Nervous Disorders Yes☐ No☐
- Pacemaker Yes☐ No☐
- **Pregnancy** Yes☐ No☐
  If Yes due date: _____
- **Possible Pregnancy** Yes☐ No☐
- Radiation Treatment Yes☐ No☐
- Respiratory Problems Yes☐ No☐
- Rheumatic Fever Yes☐ No☐
- Rheumatism Yes☐ No☐
- Tuberculosis Yes☐ No☐
- Ulcers Yes☐ No☐
- Venereal Disease Yes☐ No☐
- Penicillin Allergy Yes☐ No☐
- Other Allergies: _____
- Have you ever taken Fen-Phen or Redux? Yes☐ No☐
- Sinus Problems Yes☐ No☐
- Thyroid Problems Yes☐ No☐

- I usually take antibiotic prior to dental treatment Yes☐ No☐
- Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition Yes☐ No☐
- List of medication you are taking: _____
- 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: _____
- I have had a major surgery Yes☐ No☐ Year_____ Type of operation_____
- Are you now under the care of a physician? ☐ Yes ☐ No Name of Physician_____ Phone: _____
  If yes, please explain: _____
- Who should we contact in case of an emergency _____

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.
The fact sheet describing and comparing the risks and efficacy of the various types of dental restorative materials by the dental board of California was provided to me.

_____ Date: _____ _____ Date_____
Signature of patient, parent or guardian Signature of Doctor

Patient Information and Medical History Update

I Have reviewed the attached Medical History, Changes are as follows If no Change, Write "No Change"

Please Sign at Your 6 Month Check Up:

_____ Date: _____ _____ Date_____
Signature of patient, parent or guardian Signature of Doctor

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 Phone

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: _____

_____

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 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 Hereby authorize a debit on the account designated within this agreement, not to exceed the amount agreed to by me. I understand that checks / drafts returned for insufficient funds (NSF) will be electronically debited from my account plus a return fee of $25.00.

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