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? _____
Street City State Zipcode ☐ Own ☐ Rent

Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor Email Address _____

Driver's License No. _____ Social Security No. _____ Res. Phone _____

Employed by _____ For how long? _____ Cell Phone _____

Employer Address _____ Occupation _____
Street City State Zipcode Bus. Phone _____

Spouse's Name _____ Driver's License No. _____ Soc. Sec. No. _____

Employed by _____ For how long? _____ Occupation _____

Employer Address _____ Bus. Phone _____
Street City State Zipcode

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Res. Phone _____
Street City State Zipcode

Name of Physician _____ Telephone _____

Physician's Address _____ ☐ I have no physician
Street City State Zipcode

Former Dentist _____ Telephone _____

Dentist's Address _____
Street City State Zipcode Do you wish to speak to the doctor privately?

Why are you changing dentists? _____ ☐ Yes ☐ No

Purpose of appointment? _____

Is this office visit for Emergency Dental Care? ☐ Yes ☐ No If yes, please explain _____

Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____ Telephone _____

Address _____ Cell Phone _____
Street City State Zipcode

PREFERENCE OF PAYMENT: ☐ Cash on day of treatment ☐ Credit Card No. _____ Exp. Date _____

Name of Insurance Company (primary insurance) _____

Insured's Name _____ Birthdate _____ Relationship _____ Soc. Sec. No. _____

Name of Group Dental Plan _____ Group No _____ Plan No _____

Name of Insurance Company (secondary insurance) _____

Insured's Name _____ Birthdate _____ Relationship _____ Soc. Sec. No. _____

Name of Group Dental Plan _____ Group No _____ Plan No _____

TERMS & CONDTIONS

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 11/2% 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, checking **Yes** or **No.**

MEDICAL HISTORY

	YES	NO
1. Are you in good health?	☐	☐
2. Date of last physical examination? _____		
3. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
4. Have you ever had any serious illness or operation?	☐	☐
If so, what illness or operation? _____		
5. Have you ever been hospitalized?	☐	☐
If so, what was the problem? _____		
6. Are you taking any ☐ medication ☐ drugs ☐ herbs	☐	☐
If so, what? _____		
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ☐ Yes ☐ No If so, what? _____		
8. Have you ever been premedicated with antibiotics for your dental treatment?	☐	☐
9. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other	☐	☐
If Other, what drugs? _____		

10. Do you have or have you had any of the following: (Please check the corresponding box either 'YES' or 'No' - answer for all conditions):

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	AIDS	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Rheumatic Fever	☐	☐	Mitral Valve Prolapse
☐	☐	Anemia	☐	☐	Tonsilitis	☐	☐	Blood Disease	☐	☐	Tuberculosis (T.B.)	☐	☐	High Blood Pressure
☐	☐	Herpes	☐	☐	Hemophilia	☐	☐	Heart Ailments	☐	☐	Blood Transfusion	☐	☐	HIV Related Complex
☐	☐	Stroke	☐	☐	Cold Sores	☐	☐	Heart Attack	☐	☐	Joint Replacement	☐	☐	Respiratory Disease
☐	☐	Ulcers	☐	☐	Emphysema	☐	☐	Cerebral Palsy	☐	☐	Nervous Disorders	☐	☐	Epilepsy or Seizures
☐	☐	Diabetes	☐	☐	Rheumatism	☐	☐	Drug Addiction	☐	☐	Tumors or Growths	☐	☐	Psychiatric Treatment
☐	☐	Arthritis	☐	☐	Chicken Pox	☐	☐	Kidney Disease	☐	☐	Allergies or Hives	☐	☐	Hepatitis or Jaundice
☐	☐	Asthma	☐	☐	Bruise Easily	☐	☐	Chemotherapy	☐	☐	Pain in Jaw Joints	☐	☐	Difficulty Swallowing
☐	☐	Cancer	☐	☐	Head Injuries	☐	☐	Stomach Ulcers	☐	☐	Artificial Prosthesis	☐	☐	Congenital Heart Lesions
☐	☐	Seizures	☐	☐	Heart Failure	☐	☐	Angina Pectoris	☐	☐	Sickle Cell Disease	☐	☐	X-Ray or Cobalt Treatment
☐	☐	Hay Fever	☐	☐	Scarlet Fever	☐	☐	Mental Disorder	☐	☐	Cortisone Medicine	☐	☐	Radiation Treatment of any kind
☐	☐	Implant (s)	☐	☐	Sinus Trouble	☐	☐	Thyroid Disease	☐	☐	Allergies to Metals	☐	☐	Venereal Disease (Syphilis, Gonorrhea)
☐	☐	Headaches	☐	☐	Heart Murmur	☐	☐	Fainting Spells	☐	☐	Excessive Bleeding	☐	☐	TMJ (Temporomandibular Joint) Disorder

11. Do you have any other disease(s), condition(s) or problem(s) not listed?	☐	☐
If so, what? _____		
12. Do you wear a cardiac pacemaker, or have you had heart surgery?	☐	☐
13. Do you smoke? if yes, how much? _____ ☐ Cigarettes ☐ Cigars ☐ Packs per day	☐	☐
14. Have you ever taken the drugs ☐ Fen-Phen ☐ Redux ☐ diet drugs?	☐	☐
15. (Women) Are you pregnant? If so, how many months? _____	☐	☐
16. (Women) Do you have any problems associated with your menstrual period?	☐	☐
17. (Women) Do you take any birth control medication or hormones?	☐	☐

DENTAL HISTORY

	YES	NO
1. Have you ever had a local anesthetic (Novocaine, etc.)?	☐	☐
2. Have you ever had any unfavorable reaction to local anesthetic?	☐	☐
3. Have you had any serious trouble associated with any previous dental treatment?	☐	☐
If yes, please explain _____		
4. How long since your last full mouth X-Rays? Weeks _____ Months _____ Years _____		
5. How long since your last dental treatment? Weeks _____ Months _____ Years _____		
6. Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely?	☐	☐
7. Would you desire to be pre-sedated?	☐	☐

(A) Signature _____ Date _____

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

	YES	NO
1. Have you seen a medical doctor?	☐	☐
2. Have you had a change in your medication?	☐	☐
3. Have you had a change in your medical condition or had surgery?	☐	☐

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

Signature _____ Date _____

REVIEWED BY	DO NOT WRITE IN THIS SPOT		
(A) _____ Date _____		(A)	(B)
(B) _____ Date _____	DATE		
	B.P.		
	PULSE		
	TEMP		
	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 Healthy 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 informs of all possible complications of the procedures, anesthetics and / or drugs.

All services are rendered under the terms and conditions.

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.

Signature _____ Date _____