Patient Information

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

Social Security #:_____ Birth Date:_____Gender:_____Family Status:_____

Phone(Home):_____ (Work):_____ *(Ext):*_____ (Cell):_____

Email:_____

Preferred contact method for treatment information and invoicing?_____*

*E-mail is inherently not a secure means of communication and we can never guarantee the privacy of medical and billing information if communicated by e-mail.

Address: _____
Street Apartment #

_____
City State Zip Code

I give my consent to speak to _____ in regards to my account and treatment.

Name of Parent/Guardian/Responsible Party(s) if patient is a minor or is disabled: _____
Contact info if different from above: _____

Responsible Party Information

Without any exception or possibility of this rule being disclaimed, patient (if adult) and legal guardian (if patient is a minor or disabled) is always (1) responsible for 100% of payments due for services, (2) the party to whom any claims will be rightfully pursued against, and (3) the party for whom consent to treatment is required. If patient indicates another adult should *also* be responsible (such as a spouse or parent), claims will be billed to them for only as long as they consent and nothing about this arrangement changes the primary responsibility of patient or legal guardian. Past Due claims are 100% the obligation of patient/legal guardian.

The following contact information is for any person additionally responsible for payment in addition to patient or guardian and to whom patient/guardian necessarily gives consent to discuss patient/guardian treatment information and financial obligations:

Name: _,_____

Relationship to Patient: _____Email:_____

Phone(Home): _____ (Work): _____ (Ext):_____ Cell:_____

Address: _____
Street Apartment #

_____
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: _____

_____

Referral Information

How did you find us? Or, if referred by another person, whom may we thank for referring you to our practice? :

_____

Patient Name: _____ Date: _____

Health Information

For your safety, please review carefully and completely. Please check (Y="yes", N="no") all those that apply to the patient's health history:

Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	Heart Disease/Attack	☐	☐	Respiratory Problems
☐	☐	Anemia	☐	☐	Heart Murmur/MVP	☐	☐	Rheumatic Fever
☐	☐	Arthritis/ Rheumatism	☐	☐	Hepatitis	☐	☐	Sinus Problems
☐	☐	Artificial Joints	☐	☐	High Blood Pressure	☐	☐	Stents
☐	☐	Asthma	☐	☐	Jaundice	☐	☐	Stomach Problems
☐	☐	Blood Disease	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Cancer/Chemo	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Psychological Care	☐	☐	Thyroid Problems
☐	☐	Dizziness	☐	☐	Nervous Disorders	☐	☐	Ulcers
☐	☐	Epilepsy/Seizures	☐	☐	Currently Pregnant/Nursing Due date:_____	☐	☐	Venereal Disease
☐	☐	Excessive Bleeding				☐	☐	Emphysema
☐	☐	Fainting				☐	☐	**COVID-19** Dates:_____
☐	☐	Glaucoma	☐	☐	Pacemaker			
☐	☐	Growths/Tumors	☐	☐	Radiation Treatment			
☐	☐	Hay Fever						
☐	☐	Head Injuries				☐	☐	OTHER: _____

Weight_____*

*Please note that most dental chairs have a weight limit of 300 lbs. and may break if that limit is exceeded. To prevent risk of head or other injury to patient we are not able to treat patients that exceed this safety limit.

- Please list any current medications: _____
- Please list allergies to medications or substances:_____
- 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: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
- If yes, please explain: _____
- Have you ever taken medications for osteoporosis and/or cancer? _____

Dental Information

What is the reason for your visit today?_____
Date of last dental visit: _____Last cleaning: _____Last Full mouth x-rays: _____
Previous Dentist's Name: _____Phone: _____
Address: _____
How often do you have dental examinations? _____How often do you brush? _____Floss? _____
Do you have any dental problems now? : _____

Do you:

Clench or grind your teeth?	Yes	No	Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No	Smoke/Chew tobacco?	Yes	No
Bite your lips or cheeks regularly?	Yes	No	Hold foreign objects in your teeth?	Yes	No
Do you feel nervous about having treatment?	Yes	No	Any TMJ issues?	Yes	No
Do you want a whiter smile?	Yes	No	Do you snore?	Yes	No

The above health history and dental information is factual and complete to the best of my knowledge and I understand that, for my own safety, if I ever have any change in my health I must update the doctor at the next appointment prior to any services being performed:

_____Date: _____
Signature of patient, parent or guardian

_____Date: _____
Dentist Signature

Patient Name: _____ Date: _____

Consent to Office Policies

1. **Office and Financial Policies and Consent for Internet Communications (must be signed by ALL patients).**

   By signing below, I acknowledge that I read the Office and Financial Policies form, adopted June 19, 2018, and the Consent for Internet Communications form, that these policies are herein incorporated to this document by reference, and that I understand and consent to these policies in their entirety.

   Signature_____Date_____
   (If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above.)

2. **Notice of Privacy Practices (must be signed by ALL patients).**

   By signing below, I acknowledge that I have received a copy of the terms of the Notice of Privacy Practices, adopted April 14, 2003 and consent to the same.

   Signature_____Date_____
   (If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above.)

3. **Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance).**

   To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

   Signature_____Date_____
   (If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign above.)

Consent for Services

By signing below I certify the following:

I have read and understand all questions contained in this form and I acknowledge that all questions have been answered truthfully to the best of my knowledge.
I consent to the dentist to perform examinations and diagnose my condition and for any basic preventative or basic restorative procedures which may be necessary. I consent to x-rays, study models, photographs deemed appropriate for diagnosis. I authorize all recommended treatment mutually agreed upon by me. I agree to the use of anesthetics, sedatives and other medications as necessary. I agree to the call of emergency services in the event dentist, staff, or patient identifies an emergency and agree that any and all emergency costs are my financial responsibility. I realize my doctor may discover conditions which may require different treatment from that which was planned and I give my permission for those other procedures that are advisable in the exercise of professional judgement to complete my treatment. I understand that I am financially responsible for any and all services and products received.
I fully understand that undergoing dental/medical care, using anesthetic agents, and using medications embodies certain serious health risks ranging from minor complications to death. I understand it is therefore very important that I am honest and compete in my health history and that I can ask for a complete recital of any possible complications at any time and, if I feel I do not understand any risk or any information related to me by dentist, it is my responsibility to inform the doctor and staff, *prior to treatment*, so they can assist my understanding till I am comfortable. I understand I may withdraw consent for treatment not yet received at any time but also understand that not obtaining recommended treatment for a dental/medical problem may also come with serious health risks that may grow worse with time and lack of care.
I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment if different from patient, parent or guardian