About you:

Name: _____ Age:_____ D.O.B: _____

SS#: _____ Marital Status:_____

Home Address:_____ City:_____ Zip:_____

Home #_____ Cell#:_____ Text Messages Okay? Yes/No

Email Address:_____

Employer:_____ Work #:_____

Emergency Contact:_____ Emergency Contact# _____

Pharmacy Name/City Location: _____

Spouse Information:

Spouse's Name:_____ Spouse's DOB:_____

Spouse's #:_____

Please list names of people we are allowed to speak with regarding your personal information:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Who may we thank for referring you?_____

Insurance:

Name of the insurance carrier:_____ Phone #:_____

Name of subscriber:_____ DOB:_____

ID # or the subscriber's SS#:_____ Group #:_____

Is there secondary Insurance? YES / NO

Name of the insurance carrier:_____ Phone #:_____

Name of subscriber:_____ DOB:_____

ID # or the subscriber's SS#:_____ Group #:_____

Acknowledgement of Receipt of Privacy Notice:

I acknowledge that I have reviewed the notice of privacy practices. I have been given an opportunity to ask any questions that I may have at this time regarding the privacy notice. I am also aware that I may contact the privacy officer if I have any future questions. I authorize this practice to leave a message on my answering machine/voicemail or with a person who may answer my home phone number either to confirm a scheduled appointment or to respond to a specific inquiry that I may have requested from this practice. Furthermore, I authorize this practice to contact me at my place of employment regarding the same.

Signature:_____ Date:_____

If the patient is a child or requires a guardian

Guardian's Signature:_____ Date::_____

Consent for Service:

I authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and/or other medications as indicated. I also understand that it is my responsibility to inform this office of any changes to my medical status.

Signature:_____ Date:_____

If the patient is a child or requires a guardian

Guardian's Signature:_____ Date:_____

As a condition of your treatment by the office, financial agreements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibilities on the part of each patient must be determined before treatment. All emergency dental services or any dental services furnished are charged directly to the patient and he or she is personally responsible for payments of all dental services. The office will help prepare the patient's insurance forms or assist in making collections from the insurance companies and will credit such collections to the patient's account. However, this dental office cannot render service on the assumption that our charges will be paid by the insurance company. Co-pays will be collected at the time of service. A service charge of one and a half percent per month on any unpaid balance will be charged on all accounts exceeding 30 days unless previously written financial agreements are satisfied in advance. You agree to reimburse us the fees of any collection agency, which may be based on a percentage of a maximum of 33% of the debt, and all costs and expenses including reasonable attorneys fees we encourage and such collection efforts.

I understand that the fee estimate listed on any treatment plan for dental care can only be extended for a period of six months from the date of patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the reasonable value of said service to said doctor, or his assignee, at the time of services rendered or within five days of billing IF credit shall be extended. I further agree that the reasonable value of said service 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 shall not constitute a waiver of any further term or condition. 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 my place of work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agreed to their content.

Signature:_____ Date:_____

If the patient is a child or requires a guardian

Guardian's Signature:_____ Date:_____

Dental Concerns:

What is the reason for your visit today?_____

Do you have any questions or concerns about your teeth?

_____

What would you change about your teeth?_____

How many times a day do you brush?_____ Floss?_____

Do you use tobacco products?_____ Vape?_____

When was your last dental visit?_____

Why did you leave your last dentist?_____

Have you ever had a reaction to local anesthesia?_____

Have you had your wisdom teeth removed? YES / NO When?_____

Medications

Please list any and all medications you are currently taking

_____

_____

_____

_____

Do you need to premedicate for dental treatment? YES / NO

Allergies:

Circle any of the following you may be allergic to :

Aspirin	Erythromycin	Tetracycline
Codeine	Latex	lead or metal alloys
Dental Anesthetics	Penicillin	Amoxicillin

Other :_____

Health History:

Do you have any general health problems? YES / NO

If so, please specify:_____

Have you had surgery: YES / NO

If so, please specify:_____

Are you under a physician's care? YES / NO Reason:_____

Are you pregnant? YES / NO What is your due date?_____

To the best of your knowledge have you ever been afflicted with: (circle all that apply)

Arthritis	Rheumatic / Scarlet Fever	Glaucoma
Artificial Bones/ Joints	Mitral Valve Prolapse	Kidney Problems
Epilepsy/ Seizures	Heart Murmur	Fever Blisters/ Herpes
Sinus Problems	Heart Attacks	Psychiatric Problems
Blood Transfusion	Heart Surgery/ Pacemaker	Stroke
Hemophilia/ Abdominal Bleeding	Congenital Heart Defect	Severe/ Frequent Headaches
Hepatitis: Type_____	Artificial Heart Valves	Shingles
HIV +/ AIDS	High/ Low Blood Pressure	Venereal Disease
Diabetes: Type _____	Anemia	Ulcer / Colitis
Healing Complications	Asthma/ Emphysema	Drug / Alcohol Abuse
Cancer/ Chemo / Radiation	Tuberculosis	Hospitalization

If you are afflicted with something not listed above, please enter below:

_____

I certify the above statements regarding my medical conditions to be accurate and true to the best of my knowledge.

Signature: _____