

Today's Date: _____

New Patient Information Form

Name: _____ Male Female

Birth date: _____ SSN: _____

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Mailing Address: _____

Email Address: _____ (We confirm appointments)

Marital Status: Single Married Divorced Widowed

Employer: _____ Occupation: _____

Work Address: _____ Phone: _____

Name of Spouse (parent, if minor): _____

Spouse's Birth date: _____ Spouse's SSN: _____

Spouse's Employer: _____ Phone Number: _____

Referral Information

Whom may we thank for referring you to our practice?

Another Patient/friend who: _____ Another Doctor Radio Ad School

Work Phonebook Other _____

Insurance Information

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID#: _____ Group# _____

Insured's Employer Name: _____

Patient's relationship to Insured: Self Spouse Child Other _____

Insurance Plan Name and Telephone Number: _____

Assignments of Benefits/Release of Information

I authorize payment of dental benefits to the named provider for professional services rendered. I authorize the release of any dental information necessary to process claims.

Signature: _____ Date: _____

Name: _____ Today's Date: _____

Medical History

Are you under a physician's care now? Yes No

If yes, for what? _____

Any Medical Alerts? _____

Family Physician: _____ Phone: _____

Mark any of the following, which **you have had or have** at the present:

- | | | |
|---|---|---|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Eye Problems | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> <input type="checkbox"/> Fainting Tendency | <input type="checkbox"/> <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Mental Disabilities |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> <input type="checkbox"/> Physical Disabilities |
| <input type="checkbox"/> <input type="checkbox"/> Blood Disease | <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> <input type="checkbox"/> Chemo/Radiation Therapy | <input type="checkbox"/> <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> <input type="checkbox"/> TMJ |
| <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | |

Are you currently taking any medications? Yes No

If so, which? _____

Have you taken or are you taking Bisphonate drugs? No Yes, when? _____

Are you allergic to or do you suffer ill effects from any of the following?

- Tetracycline Metals/Jewelry Latex Penicillin Codeine Dental Anesthesia Aspirin
 Erythromycin Other: _____

Women Only:

Are you pregnant? No Yes, how many weeks? _____ Breast Feeding? No Yes

Are you taking routine medicine (Birth Control, etc.)? No Yes, which? _____

Signature: _____

Dental History

Date of Last Exam: _____ Date of Last Cleaning: _____

Date of Last Xray: _____

Do you wear dentures or partials? _____

Are you happy with your dentures or partials? _____

Are you having dental problems now? _____

If yes, what? _____

Do you use tobacco? No Yes, how long? _____ How much per day? _____

Have you had bad dental experiences in the past? No Yes

Have you had any periodontal (gum) treatments? No Yes, when? _____

Do your gums bleed, or feel tender or irritated? No Yes

Are your teeth sensitive to hot, cold, sweets, or pressure? No Yes

Are you unhappy with the appearance of your teeth? No Yes

Are you aware of grinding or clenching your teeth? No Yes

Do you have headaches, earaches or neck pains? No Yes

Do you have pain in your jaw joint? No Yes

Do you regularly use dental floss? No Yes

Do you have trouble sleeping? No Yes

Is there any other medical or dental information that you feel I should know about? _____

Name of Previous Dentist: _____

Address: _____

City, State, Zip: _____ Phone: _____

The above information is true to the best of my knowledge.

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

Signature: _____ Date: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

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 patient's 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 2.00% per month (24% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) 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 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 have read the above conditions of treatment and payment and agree to their content.

Signature: _____ Date: _____

Relationship to Patient: _____