



HEALTH HISTORY:

Last Name, First Name, MI, Preferred Name, Address, City, State, Zip Code, Date, Email Address, HM Phone, Cell Phone, WK Phone, Birthdate, Age, Sex, Status, Patient SS#, Occupation, Employer Name, Employer Phone, Employer Address, Spouse Name, Birthdate, Occupation, Spouse's Employer

INSURANCE INFORMATION:

Whom may we THANK for referring you?, Who is responsible for this account?, Relationship to patient, PRIMARY Insurance, Phone #, Is pt. covered by additional ins?, Insurance Address, Group Number, Subscriber's Last Name, First Name, MI, Subscriber's Birthdate, Subscriber's SS# or ID#, Patient's relationship to insured, SECONDARY Insurance, Phone #, Is pt. covered by additional ins?, Insurance Address, Group Number, Subscriber's Last Name, First Name, MI, Subscriber's Birthdate, Subscriber's SS# or ID#, Patient's relationship to insured

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature, Relationship, Date

DENTAL HISTORY:

Reason for today's visit, Former Dentist, Address, Phone #, Date of last dental visit, Date of last dental X-RAYS

Please CHECK to indicate if you have had any of the following and when:

- Bad breath, Bad experience in dental office, Bleeding Gums, Blisters on lips or mouth, Burning sensation on tongue, Chew on one side of mouth, Chewing tobacco, Dry mouth, Difficult with previous dental work, Do you have click & pop in jaw joint, Do you like your smile, Do you have Implants, dentures, partials, Food or floss catch between teeth, Foreign objects, Fingernail biting, Grinding teeth - consciously or sleep, How often do you brush?, How often do you floss?, Jaw pain or tiredness, Lip or cheek biting, Loose teeth or broken fillings, Mouth breathing, Nervous or bad experience, Orthodontic treatment, Pain around ear or neck pains, Periodontal history, Problems getting numb, Sensitivity to cold or hot, Sensitivity to Sweets or pressure, Sensitivity when Biting, Smoking - Cigarettes, pipe, cigars, Sores or growths in mouth, Types of Bristles - Soft Medium Hard

If you could change anything about your mouth, teeth, or smile, what would it be?

MEDICAL HISTORY:

Although dental personnel primarily treat the areas in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name _____ Phone Number _____ Date of last visit _____

Please CHECK to indicate if you have had any of the following and when:

AIDS	Cortisone Medicine	Herpes	Recent Weight Loss
Alzheimer's Disease	Diabetes I or II	High Blood Pressure	Renal Dialysis
Anaphylaxis	Drug Addiction	High Cholesterol	Rheumatic Fever
Anemia	Easily Winded	HIV Positive	Rheumatism
Angina	Emphysema	Hives or Rash	Scarlet Fever
Arthritis / Gout	Epilepsy or Seizures	Hypoglycemia	Shingles
Artificial Heart Valve	Excessive Bleeding	Irregular Heartbeat	Shortness of Breath
Artificial Joint	Excessive Thirst	Joint Replacements _____	Sickle Cell Disease
Asthma	Fainting Spells / Dizziness	Kidney Problems	Sinus Trouble
Back Problems	Frequent Cough	Lesion	Skin Cancer _____
Blood Disease	Frequent Diarrhea	Leukemia	Special Diet _____
Blood Transfusion	Frequent Headaches	Liver Disease	Spina Bifida
Breathing Problem	Genital Herpes	Low Blood Pressure	Stomach Disease
Bruise Easily	Glaucoma	Lung Disease	Stroke _____
Cancer _____	Hay Fever	Mitral Valve Prolapse _____	Swelling of Limbs
Chemical Dependency	Heart Attack _____	Nervous Problems	Thyroid Disease
Chemotherapy	Heart Murmur	Osteoporosis	Tonsillitis
Chest Pains	Heart Pacemaker _____	Pain in Jaw Joints	Tuberculosis
Circulatory Problems	Heart Trouble / Disease	Parathyroid Disease	Tumors or Growths
Cold Sores / Fever Blister	Hemophilia	Psychiatric Care	Ulcers
Congenital Heart Disorder	Hepatitis A	Radiation treatments	Venereal Disease
Convulsions	Hepatitis B or C	Respiratory Disease	Yellow Jaundice

Have you ever had any serious illness not listed above? _____

Have you ever had any Surgery and date not listed above? _____

WOMEN ONLY:

Pregnant? _____ Due Date _____ Nursing? _____

Taking Birth Control Pills _____ Taking Hormonal Replacement _____

ALLERGIES:

Acrylic	Clindamycin	Iodine	Morphine
Amoxicillin	Codeine	Latex	Penicillin
Aspirin	Epinephrine	Local Anesthetics	Sulfa Drugs
Barbiturates	Erythromycin	Loratab	Tetracycline
Chlorhexidine	Keflex	Metal	Tylenol

Other Please explain _____

MEDICATIONS:

Are you taking any medications, pills, or drugs? If yes, please explain what medications are for:

___ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

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 performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who carry dental insurance understand that all dental service 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 assumptions that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annually) 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 estimated listed for this dental care can only be extended for a period of 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 therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within 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, text message, email me at home or work to discuss matters related to this form. I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

___ Initial INSURANCE: You are responsible for the entire balance of any treatment you receive. We will be glad to file your insurance electronically. Due to the large variety of insurance companies and plans, we are unable to determine the exact amount of coverage for each plan at the time of treatment. Your insurance coverage will be estimated and the remaining balance is due at time of treatment.

___ Initial MISSING APPOINTMENT / LATE CANCELLATION: Please give us the courtesy of 2 business days' notice if you are unable to make your appointment. If adequate notice is not given, a missed appointment or late cancellation charge will be applied to your account in the amount of \$50.00 for each hour of time scheduled.

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic acts deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (Name of Patient)

_____ and further authorize and consent that the Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made in writing. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days from when treatment was received. In event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature _____

Date _____

Parent or Responsible Party _____

Relationship to Patient _____