Patient **Information**

Today's Date*:* **<<Todays_Date>>**

Patient's Name: <<Pat_LastName>>, <<Pat_FirstName>>
Last, First MI (Preferrd Name)

Address: <<Pat_StreetAddress>> <<Pat_Suite>> **City:** <<Pat_City>> **State:** <<Pat_State>> Zip: <<Pat_ZipCode>>

Gender: <<Pat_Sex_M_F>> **Family Status**: <<Pat_MaritalStatusAsChar>>

Social Security # <<Pat_SSN>> **Birth Date:** <<Pat_BirthDate>>

Phone (Home): <<Pat_HomePhone>> **(Work)**: <<Pat_WorkPhone>>

(Cell) Phone: <<Pat_MobilePhone>>

E-mail address: <<Pat_Email>>

HEALTH INFORMATION

Do you currently have (or have a history of) any of the following conditions? Check those that apply

ADD/ADHD	Dizzy Spells	Irregular Heartbeat	Rheumatic Fever
AIDS/HIV	Epilepsy	Irritable Bowel Syndrome	Rheumatism
Allergy Rx medication	Fainting Spells	Jaundice	Rheumatoid Arthritis
Alzheimer's Disease	Fatigue	Kidney Disease	Seizures/Convulsion
Alcohol/Drug Abuse	Free Bleeder	Liver Disease	Shortness of Breath
Anaphylaxis	Glaucoma	Lupus	Sinus Problems
Anemia	Gout	Memory Loss	Sleep Problems
Antibiotic Prophylaxis Needed	Hayfever/Allergies	Menopause	Smoker
Anxiety	Headache	Mental Disorder	Snoring Habit
Arthritis	Head Injuries	Mitral Valve Prolapse	Stressed Out
Artificial Joints	Heart Attack	Nervous Disorder	Stroke History
Asthma	Heart Burn	Obesity	Sweet Snack Habit
Blood Disease	Heart Condition	Osteoporosis	Swelling Ankles
Bruises Easily	Heart Murmur	Pacemaker	Thyroid Disease
Cancer History	Heart Surgery	Parkinson's Disease	TMJ Problems
Chemotherapy	Hepatitis	Pregnancy Complication	Tooth Clenching Habit
Chest Pain	High Blood Pressure	Pregnant? Yes No	Tuberculosis
Compromised Immune System	High Cholesterol	Due Date _____/201	Tumor History
Constipation	High Triglycerides	PreMenstrual Syndrome	Ulcers
Dental Phobia	Hives/Skin Rash	Prostate Problems	Venereal Disease
Depression	Hormone Replacement	Radiation Treatment	Weight Management Problems
Diabetes	Implant Prosthesis	Respiratory Problems	
Digestion Problems	Inner ear Infections	Respiratory Infections	OTHER
Diverticulitis	Insomnia		

Please list **all current medication** you take (prescription & over-the-counter) and **reason** for taking:
(example: insulin (diabetes)

RX Medication	Condition Treated	Rx Medication	Condition Treated

Date of Last Dental Visit: _____ Reason for this visit: _____

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:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of patient, parent or guardian (updated medical history)

SPOUSE / EMERGENCY CONTACT INFORMATION

Relationship to patient is: the patient's spouse family member other

Name: _____

Social Security #: _____ Birth Date:

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call _____

Address: _____

CONSENT FOR SERVICES and RELEASE OF INFORMATION

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, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account.

I understand that the fee estimate listed for this dental care can only be extended for a period of six 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 five (5) days of billing if credit shall be extended.

_____ 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 grant my permission to you or your assignee, to disclose and/or transfer any personal information pertaining to my diagnosis and/or treatment. I understand that each doctor must obtain the same disclosure according to the provisions stated in the Health Insurance Portability and Accountability Act (HIPAA).

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

X_____ Date _____

Signature of patient, parent or guardian

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

Another patient, friend; Another patient, relative; Dental Office;
Yellow Pages; Newspaper; School;
Work: Other;

Name of person (or office) referring you to our practice. _____