



Today's Date: _____

PATIENT INFORMATION

PATIENT'S NAME Last: _____ First: _____ Middle Initial _____ SEX: M F AGE: _____

Soc. Sec. # _____ BIRTHDATE _____ If Patient is a Minor, give Parent's or Guardian's Name _____

Reason for this Visit _____

Who may we thank for referring you to our office? Friend Relative Referring Physician Name: _____ SBC Ameritech Smithville Phone book Yellow Book Internet website Other: _____**RESPONSIBLE PARTY INFORMATION**

NAME Last _____ First _____ Middle _____ MARITAL STATUS _____

SOCIAL SECURITY # _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

RESIDENCE Street address _____ City _____ State _____ Zip _____

HOW LONG at this address? _____ Yrs HOME PHONE (_____) _____ WORK (_____) _____ CELL (_____) _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How long? _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSENAME _____
LAST FIRST MIDDLE

EMPLOYER _____ NO. YEARS EMPLOYED _____

OCCUPATION _____ SOC. SEC. # _____

WORK PHONE _____ BIRTHDATE _____

**EMERGENCY INFORMATION:
RELATIVE NOT LIVING WITH YOU**

NAME _____

ADDRESS _____

CITY, STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____ Birthdate _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group# _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____ Birthdate _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group# _____ Local # _____

*** PATIENT MEDICAL HISTORY ***

Do you have any CURRENT HEALTH PROBLEMS? YES NO
 Are you under a PHYSICIAN'S CARE now? YES NO

For What? _____

What MEDICATIONS (including over-the-counter) do you take? _____

What SUPPLEMENTS (including herbal) do you take? _____

Women: PREGNANT? No Yes, due date: _____

Take BIRTH CONTROL PILLS?

Do you SMOKE? _____ # Pack/Day/or Other Tobacco? _____ YES NO

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

- | | | |
|--------------------------|--|---------------------------------|
| Heart Disease or Attack | A.I.D.S./HIV Positive | Tuberculosis (TB) |
| Angina Pectoris | Hepatitis A (infectious) | Asthma |
| High Blood Pressure | Hepatitis B (serum) | Sinus Trouble |
| Heart Murmur | Liver Disease | Allergies or Hives |
| Rheumatic Fever | Drug Addiction | Diabetes |
| Congenital Heart Lesions | Hemophilia (Bleeding Problems) | Thyroid Disease |
| Mitral Valve Prolapse | Fever blisters | Chemotherapy (Cancer, Leukemia) |
| Artificial Heart Valve | Epilepsy or Seizures | Radiation Treatment |
| Heart Pacemaker | Glaucoma | Arthritis |
| Heart Surgery | Artificial Joints (Hip, Knee) | Pain in Jaw Joints |
| Stroke | Venereal Disease (Syphilis, Gonorrhea, etc.) | Alcoholism |
| Kidney Trouble | Gonorrhea, etc.) | Emphysema |
| Ulcers | Herpes | |

CIRCLE ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

- | | | |
|---------------------|------------------|------------|
| Latex Allergy | Local Anesthetic | Penicillin |
| Aspirin | Codeine | |
| Nitrous Oxide (Gas) | Erythromycin | |

Are you aware of being allergic to any other medications or substances? _____

If yes, please list: _____

Is there any other Medical or Dental information that you feel we should be aware of?

YOUR PHYSICIAN _____

*** PATIENT DENTAL HISTORY ***

HOW LONG since you have seen a Dentist? _____

Is your present dental health GOOD FAIR POOR

	YES	NO
Are you having PROBLEMS now?	<input type="checkbox"/>	<input type="checkbox"/>
Are you AFRAID OR NERVOUS about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED, or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure ? (circle any)	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT?	<input type="checkbox"/>	<input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>

How do you feel about your teeth? _____

*** FINANCIAL POLICIES ***

- FINANCE CHARGE** – I agree to pay up to 1 1/2% per month (18% Annual Percentage Rate) on any balance over 60 days old.
- BILLING CHARGE** – I agree to pay up to \$5 per month for billing costs, if any balance must be billed over 60 days.
- COLLECTION COSTS** – I agree to pay any **attorney fees, court costs**, and a **35%** Collection Fee if collection by a third party is necessary.
- BAD CHECK CHARGE** – I understand that a **\$20** charge will be added to my balance if any check is returned for insufficient funds.
- MISSED APPOINTMENTS** – I understand there will be a \$20 charge for missed appointments without 24 hour notification.
- RESPONSIBLE PARTY** – The parent/guardian who presents a **minor child** for treatment is responsible for payment of the account, regardless of any court orders stating otherwise, unless **written** permission to bill another party is presented to our office at the time of service.

The information I have given today is correct to the best of my knowledge. It is my responsibility to **inform** this office of any changes in medical status. I authorize the dental staff to **perform any necessary dental services** with my informed consent that may be needed during diagnoses and treatment. I authorize **release of any information** including the diagnosis and records of any treatment rendered to me or my child to **insurance companies or health practitioners**. I authorize and request my insurance company to **pay directly to the dentist** benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to pay any amount not covered. I understand the **Financial Policies** and agree to be **responsible for payment** of all services rendered to me or my dependents.

SIGNATURE OF PATIENT or RESPONSIBLE PARTY:

DATE: _____