Patient Information							
Patient Name:					_Date:		
Address:	Last	First	MI	Preferred Name			
	Street				Apartment #		
	City		State		Zip Code		
Employer:							
	Family Status: 🛛 Married 🗆 Divorced 🗆 Single 🗆 Child 🗆 Other:						
		Birth Date:					
Phone: Cell Dense check number to be used for appointment reminders							
Emergency Conta	act Name		_ Phone		_ Relationship		
l agree to receive	e emails from th	e practice □ Yes □ No					
Spouse, Parent, or Responsible Party Information The following is for:							
Name:			Employer:				
Social Security #:		Birth Date:	·	Gender	: 🗆 Male 🗆 Female		
Phone: Home		Work		ext Cell:			
Address:							
		Insuranc	e Informatio	ı			
Name:	Name: Is subscriber a patient? 🗆 Yes 🗖 No						
Subscriber Birth I	Date:	Social Security #:	_Social Security #:Group#				
Subscriber's Add	ress:						
Subscriber's Employer/Address:							
Patient Relations	hip to Subscribe	er: 🗆 Self 🗆 Spouse	e 🗆 Child 🗆	] Other			
Insurance Co Nar	ne		Insurance	e Co Phone			
Insurance Co Ado	Insurance Co Address						
Consent for Services (Read Carefully)							
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 the 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 1 1/2 % per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.							
I understand that the fee estimate listed for this dental care can only be extended for a period of 30 days from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home or my work or cell to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.							
Signature of Patient, Pa	rent, or Guardian				ıt		
Signture of Guarnator of	f Payment/Responsible						
How did you hear about our practice?  Friend, relative, neighbor, etc.  Another dentist  Post Card  Mailbox Flyer  Internet  Sign/Drive-by So we may thank them, please provide name of person or dentist who referred you:							

MEDICAL HISTORY	Patient Name:	D	Date:			
Please check all of the medical	conditions/situations that apply to y	ou.				
<ul> <li>Heart Surgery</li> <li>Heart Disease</li> <li>Heart Attack</li> <li>Chest Pain</li> <li>Congenital Heart Disease</li> <li>Heart Murmur</li> <li>High Blood Pressure</li> <li>Mitral Valve Prolapse</li> <li>Artificial Heart Valve</li> <li>Heart Stent/Shunt</li> <li>Heart Pacemaker</li> <li>Sleep Apnea</li> <li>Rheumatic Fever</li> <li>Arthritis/Rheumatism</li> </ul>	<ul> <li>Stroke</li> <li>High Cholesterol</li> <li>Kidney Trouble</li> <li>Kidney Stent/Shunt</li> <li>Diabetes</li> <li>Thyroid Problems</li> <li>Osteoporosis</li> <li>➡ History of Bisphosphonates?</li> <li>Emphysema</li> <li>Chronic Cough</li> <li>Cancer</li> <li>Radiation Therapy</li> <li>Chemotherapy</li> <li>Tumors</li> <li>s? □ No □ Yes ➡ Please tell us white</li> </ul>	<ul> <li>Headaches</li> <li>Venereal Disease</li> <li>HPV Diagnosis</li> <li>Cold Sores/Fever Blisters</li> <li>HIV Positive</li> <li>Glaucoma</li> </ul>	<ul> <li>AIDS</li> <li>Blood Transfusion</li> <li>Blood Thinners</li> <li>Hemophilia</li> <li>Sickle Cell Disease</li> <li>Neurological Disorder</li> <li>Epilepsy or Seizures</li> <li>Fainting or Dizzy Spells</li> <li>Nervous/Anxious</li> <li>Psychiatric Care</li> <li>TMJ Disorder</li> <li>Smoke/Chew/Vape Tobacco</li> <li>Jaw/Ear Pain</li> </ul>			
Do you have or have you had any disease, condition, or problem not listed above? □ No □ Yes → Please list						
Are you under the care of a physician? □ No □ Yes  Please explain						
Name of Physician						
Are you taking any medication, drugs, or pills now?       □ No □ Yes ⇒ Please list         Are you aware of having an allergy (or adverse reaction) to any medication or substance?       □ No □ Yes ⇒ Please list						
What is the reason for your vis	sit today?					
Date of Last Cleaning?		Date of Last Full Set of X-Rays	?			
Have you ever been diagnosed	l with periodontal "gum" disease?	INo □Yes ➡ Date of trea	tment			
What is your goal in seeking dental care? Please check all that apply <ul> <li>Prevent problems</li> <li>Maintain current oral health</li> <li>Fix cosmetic problems</li> <li>Resolve pain only</li> </ul>						
	WOMEN: Are you pregnant? □ No □ Yes ➡ Months Are you nursing? □ No □ Yes Are you taking birth control pills? □ No □ Yes					
	Doct	or Signature:				
I understand that the information above is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (Patient Name)'s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutual agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication necessary. I fully understand that using anesthetic agents embodies certain risks; I understand that I can ask for a complete recital of any possible complications.						
Patient	Date	Witness				
Responsible Party	onsible Party Relationship to Patient					



## Medical Information Release Form (HIPAA Release Form)

Name:	Date of Birth://
<u>Release o</u>	f Information
I authorize the release of information rendered to me and claims information. T	n including the diagnosis, records, examination his information may be released to:
□ Spouse	
Child(ren)	
□ Other(s)	
Information is not to be released to	anyone.
This <b>Release of information</b> will remain ir	effect until terminated by me in writing.
Mes	sages
Please call	□ my cell number:
If unable to reach me:	
<ul> <li>you may leave a detailed message</li> <li>leave a message asking me to retur</li> <li>Other instruction:</li> </ul>	n your call
The best time to reach me is (day)	between (time)
Signed:	Date://
Witness:	Date://