

## PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

### PERSONAL

Name \_\_\_\_\_  
Last First MI (Preferred)  
Gender:  M  F Married:  Y  N Spouse: \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Address:  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone:  
Home \_\_\_\_\_ Work \_\_\_\_\_ Wireless \_\_\_\_\_  
Time to Call \_\_\_\_\_  
Place of Employment: \_\_\_\_\_  FT  PT  Retired  Not Employed  Student  
Person responsible for account:  Self  Other: \_\_\_\_\_  
SS#: \_\_\_\_\_  
How did you hear about us?  From another patient  Yellow Pages  Website  Other  
\_\_\_\_\_  
(If someone referred you here, please write down their name so we can thank them.)

### INSURANCE POLICY 1

None  
Your relationship to person insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Name of person insured \_\_\_\_\_  
Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Phone \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_  
Insurance company \_\_\_\_\_ Group # \_\_\_\_\_  
Please present insurance card to receptionist.

### INSURANCE POLICY 2

Your relationship to person insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Name of person insured \_\_\_\_\_  
Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birth date \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Phone \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_  
Insurance company \_\_\_\_\_ Group # \_\_\_\_\_

FINANCIAL AGREEMENT

- \* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- \* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- \* I agree to let this office run a credit report. [ ] Yes [ ] No If no, then all fees are due at time of service.
- \* If sent to collections, I agree to pay all related fees and court costs.
- \* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- \* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- \* I will pay a fee for appointments broken without 24 hours notice.
- \* Treatment plans may change, and I will be responsible for the work actually done.

Signature \_\_\_\_\_ Date \_\_\_\_\_

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature \_\_\_\_\_ Date \_\_\_\_\_

MEDICAL HISTORY

Name of Medical Doctor: \_\_\_\_\_ City/State \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

List all the medications or drugs you are now taking: \_\_\_\_\_ List all the medications or drugs you are allergic to: \_\_\_\_\_

[ ] None \_\_\_\_\_ [ ] None \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever or of taking fen-phen.

[ ] None \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tobacco use? If so, what kind and how much? \_\_\_\_\_

Unusual reaction to dental injections? \_\_\_\_\_

Reason for today's visit \_\_\_\_\_ Are you in pain? \_\_\_\_\_

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? \_\_\_\_\_

Do you have BiteWing x-rays that are less than 1 year old? \_\_\_\_\_

Name of former dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last cleaning and exam \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you need more space, you may continue below: