

Patient Information							
Patient Name:	Date:						
Last ☐ Male ☐ Female	First MI Married Single Child Other						
		•					
=	(Mork):		 E-mail:				
Phone (nome).	(VVOIK)	(Cell)	E-IIIaII				
Address:Street	Apartment #						
City		State Zip Code					
Health Information							
Date of Last Dental Visit: Reason for this visit: Have you ever had any of the following? Please check those that apply:							
Have you ever nad any of	the following? Please checi	tnose that apply:					
If yes, please explain: • Have you been admitted to If yes, please explain:	☐ Fosamax, Osteoporosis ☐ Glaucoma ☐ Growths/Tumor ☐ Hay Fever ☐ Head Injuries ☐ Heart Disease ☐ Heart Murmur ☐ Hepatitis ☐ High Blood Pressure ☐ Jaundice ☐ Kidney Disease ☐ Liver Disease ☐ Liver Disease ☐ a hospital or needed emerge	ency care during the past f	☐ Transplant ☐ Tuberculosis/) Emphysema ve ☐ Thyroid Disease ☐ Ulcers nt ☐ Venereal Disease ms ☐ Latex Allergy ☐ Penicillin Allergy ☐ Other				
Name of Physician:	ne of Physician: Phone:						
 Are you taking any medications, herbal supplements, or vitamins? ☐ 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.							
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:							

Spouse or Responsible Party Information							
The following is for:							
Male ☐ Female		d □ Single □	Child ☐ Other _				
Social Security #: Birth Date:							
Phone (Home):(\)							
Address:			A	partment #			
City		State	·	Zip Code			
	Employment	t Information	1				
The following is for: the patient	the person responsible for		•				
Employer Name:		_ Occupation:					
Street	City		State	Zip Code			
Insurance Information							
Primary Name of Insured:			Is insured a pat	tient? ☐ Yes ☐ No			
Name of Insured:	First	MI	·				
Insured's Birth Date:			Group #:				
Insured's Address:		City	State	Zip Code			
Insured's Employer Name:				<u> </u>			
Address:		City	State	Zip Code			
Patient's relationship to insured: [0.0					
Insurance Plan Name and Address: _	·						
_							
Secondary Name of Insured:			le insured a pat	tient? ☐ Yes ☐ No			
Name of Insured:	First	MI	-				
Insured's Birth Date:							
Insured's Address: Street Insured's Employer Name:		City	State	Zip Code			
msureu's Employer Name.				<u> </u>			
Street		City	State				
Patient's relationship to insured:	_ · _ ·	Child		<u> </u>			
Insurance Plan Name and Address: _							
	Consent for	or Services					
As a condition of your treatment by this office, financial arrange financial responsibility on the part of each patient must be deter	ements must be made in advance. The		eimbursement from the patier	nts for the costs incurred in their care and			
All emergency dental services, or any dental services performed		ents, must be paid for in ca	ash at the time services are p	erformed.			
Patients who carry dental insurance understand that all dental s office will help prepare the patients insurance forms or assist in cannot render services on the assumption that our charges will	services furnished are charged directly making collections from insurance co	y to the patient and that he	or she is personally responsi	ible for payment of all dental services. This			
A service charge of 1½% per month (18% per annum) on the u	. ,	ccounts exceeding 90 days	s, unless previously written fir	nancial arrangements are satisfied.			
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 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 me at home or at my work to discuss matters related to this form.							
I have received a copy of Notice of Privacy Policy and Practices for Dental (initials)							
When you have a schedule conflict, please notify us within 24 hours so we can change your appointment to a more convenient time. Our policy holds to a 24 hour notice or there is a \$50 cancellation fee (initials)							
I have read the above conditions of treatment and payment and agree to their content.							
	Date:	Relat	ionship to Patient:				
Signature of patient, parent or guardian							
Signature of guarantor of payment/responsible p	Date: partv	Relat	ionship to Patient:				