

Name _____ Prefer to be called _____

Name of Medical Doctor _____ City/State _____

Emergency Contact _____ Relationship _____ Phone Number _____

Purpose of Dental Visit _____ Referred By _____

Are you having any pain or discomfort at this time? _____

When was your last dental visit? _____ What was done at that time? _____

MEDICAL HISTORY

Have you ever been hospitalized or had surgery? _____

Do you require a pre-med? _____ Reason? _____ Medication? _____

Are you currently taking blood thinners or have history of bleeding? _____

List all medications you are taking _____

IF EXTENSIVE, PLEASE LIST ON BACK OR INCLUDE A COPY OF LIST

Any **allergic reactions** (hives, rash, etc) to medications? _____

Do you have any history of the following conditions?

Heart Problems

Y N

Chest Pain

Shortness of Breath

High Blood Pressure

High Cholesterol

Heart Murmur

Pacemaker

Artificial Heart Valve

Heart Surgery

Heart Attack/Failure

Blood Problems

Easy Bruising

Abnormal Bleeding

Anemia

Hemophilia

Sickle Cell Disease

Diabetes

Autoimmune Disease

Crohn's / Colitis

Lupus

Sjögren's syndrome

Multiple Sclerosis

Allergy Problems

Y N

Seasonal Allergies

Sinus problems

Skin Rashes

Intestinal Problems

Ulcers

Weight Gain/Loss

Special Diet

Kidney Problems

Dialysis

Acid Reflux / Gerd

Bone or Joint Problems

Arthritis

Rheumatism

Joint Replacement

Osteoporosis

Pain in Jaw/TMJ

Cancer

If yes what kind? _____

When was it diagnosed? _____

Treatment received? _____

Asthma

Seizures / Epilepsy

Migraine Headaches

Stroke

Thyroid Problems

Fainting / Nervousness

Tuberculosis

Hepatitis / Liver Problems

Cold Sores

Shingles

HIV / AIDS

Anxiety or Depression

Psychiatric Treatment

Do you use alcohol?

How much? _____

Do you smoke?

How much? _____

Hx of Substance abuse?

Women Are you Pregnant or planning on becoming Pregnant? _____ Are you nursing? _____

Any other condition / allergy that we should know about? _____

To the best of my knowledge all of the preceding information is accurate. I understand that it is my responsibility to inform the Doctor and staff, if I have a change in my health status, including changes in my medications and/or allergies.

Signature (Patient of Parent if Minor) _____ **Date** _____

Date: _____

Patient Information

Patient Name: _____ Birth Date: _____

Marital Status: _____ Gender: _____ Social Security # _____

Phone (Home): _____ Work: _____ Cell _____

Email: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Consent For Services

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. However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional series 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 of 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 were 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 read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to patient _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to patient _____