Patient Information

Patient Name:_____ Date:_____
Last First MI (Preferred Name)

Gender:_____ Marital Status:_____

Social Security #: _____ Date of Birth: _____

Phone (home):_____ (work): _____ (cell):_____

Address:_____
Street Apartment #

_____
City State Zip Code

EMAIL Address:_____

Emergency Contact: Name _____ Number _____

Spouse or Responsible Party Information

Name: _____

Social Security #: _____ Date of Birth: _____

Phone: (home) _____(work) _____ (cell)_____

Address (if different from above): _____
Street Apt #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice?

- ☐ Another patient _____
- ☐ Google/Internet
- ☐ Other _____

Dental Insurance Information

Insurance Company's Name: _____ Employer: _____

Insurance Company's Address: _____

Name of Insured: _____ SS# of Insured _____

Insured's date of birth: _____ ID# _____ group#_____

Secondary

Insurance Company's Name: _____ Employer: _____

Insurance Company's Address: _____

Name of Insured: _____ SS# of Insured _____

Insured's date of birth: _____ ID# _____ group#_____

HIPAA Acknowledgement

I understand that, under the Health Insurance and Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third party payers.
Conduct normal healthcare operations such as assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

_____ Date:_____ Relationship to patient_____

Signature of patient, parent or guardian

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 cost 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 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 the payment of all dental services. This office will prepare the patient's insurance forms 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 1.5% per months on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

In consideration of the professional services rendered to me, I agree to pay at the time services are rendered.

I have read the above conditions of treatment and payment and agree to their content.

_____ ____ Date:_____ Relationship to patient_____

Signature of guarantor of payment/responsible party

Health Information

Date of last dental visit:_____ Reason for today's visit_____

Please check the conditions that apply to you:

- ☐ AIDS/HIV
- ☐ Acid Reflux
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma/Respiratory Problems
- ☐ Cancer/Radiation treatment/Chemotherapy
- ☐ Current tobacco use (circle) vape usage smoke smokeless tobacco
- ☐ Cancer/Radiation treatment/chemotherapy
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Depression/Anxiety/other
- ☐ Pacemaker
- ☐ Current Pregnancy
- ☐ Stroke/Heart Attack
- ☐ Tuberculosis
- ☐ Mouth Ulcers/Fever Blisters
- ☐ TMJ problems

- **Are you allergic to any of the following?** Please circle: Penicillin Latex Hydrocodone Metal Novacaine/Xylocaine Other

  If "Other", please explain: _____

- **Please list the medications you are currently taking: _____**

  _____

- **Who is your Primary Care Physician? _____**

  Phone Number: _____

- Do you snore? Or have you been told you snore? (Circle one) Yes No

- Do you wear a CPAP? Or have you worn a CPAP in the past? Or have you been told to get a CPAP? (Circle one) Yes No

- Have you had a sleep study? Or have you been told to get one? (Circle one) Yes No