

\_\_\_\_\_  
TODAY'S DATE

**PATIENT INFORMATION**

NAME	SOCIAL SECURITY NUMBER	
BIRTH DATE	HOME PHONE	MOBILE PHONE
ADDRESS	CITY+STATE	ZIP
PLEASE CHECK THE APPROPRIATE BOX <input type="checkbox"/> MINOR <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED		
IF STUDENT, NAME OF SCHOOL/COLLEGE	CITY	STATE
PATIENT'S OF PARENT'S EMPLOYER	WORK PHONE	
BUSINESS ADDRESS	CITY+STATE	ZIP
SPOUSE OR PARENT'S NAME	EMPLOYER	WORK PHONE
PERSON TO CONTACT IN CASE OF EMERGENCY	PHONE	
WHOM MAY WE THANK FOR REFERRING YOU?	RELATIONSHIP TO PATIENT	

**RESPONSIBLE PARTY**

PERSON RESPONSIBLE FOR THIS ACCOUNT	RELATIONSHIP TO PATIENT	
ADDRESS	HOME PHONE	
DRIVER'S LICENSE	BIRTH DATE	
EMPLOYER	WORK PHONE	
CURRENTLY A PATIENT IN OUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

**INSURANCE INFORMATION**

NAME OF INSURED	RELATIONSHIP TO PATIENT	
SOCIAL SECURITY NUMBER	BIRTH DATE	DATE EMPLOYED
EMPLOYER	WORK PHONE	
EMPLOYER ADDRESS	CITY+STATE	ZIP
INSURANCE COMPANY	GROUP NUMBER	UNION OR LOCAL NUMBER
ADDRESS	CITY+STATE	ZIP
HOW MUCH IS YOUR DEDUCTIBLE?	HOW MUCH HAVE YOU USED	MAXIMUM ANNUAL BENEFIT

**ADDITIONAL INSURANCE**

NAME OF INSURED	RELATIONSHIP TO PATIENT	
SOCIAL SECURITY NUMBER	BIRTH DATE	DATE EMPLOYED
EMPLOYER	WORK PHONE	
EMPLOYER ADDRESS	CITY+STATE	ZIP
INSURANCE COMPANY	GROUP NUMBER	UNION OR LOCAL NUMBER
ADDRESS	CITY+STATE	ZIP
HOW MUCH IS YOUR DEDUCTIBLE?	HOW MUCH HAVE YOU USED	MAXIMUM ANNUAL BENEFIT

## DENTAL HISTORY

REASON FOR TODAY'S VISIT \_\_\_\_\_ DATE OF LAST DENTAL VISIT \_\_\_\_\_

FORMER DENTIST \_\_\_\_\_ DATE OF LAST DENTAL X-RAYS \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY+STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> BAD BREATH                        | <input type="checkbox"/> GRINDING TEETH                 | <input type="checkbox"/> SENSITIVITY TO HEAT     |
| <input type="checkbox"/> BLEEDING GUMS                     | <input type="checkbox"/> LOOSE TEETH OR BROKEN FILLINGS | <input type="checkbox"/> SENSITIVITY TO SWEETS   |
| <input type="checkbox"/> CLICKING OR POPPING JAW           | <input type="checkbox"/> PERIODONTAL TREATMENT          | <input type="checkbox"/> SENSITIVITY WHEN BITING |
| <input type="checkbox"/> FOOD COLLECTION BETWEEN THE TEETH | <input type="checkbox"/> SORES OR GROWTHS IN YOUR MOUTH | <input type="checkbox"/> SENSITIVITY TO COLD     |

HOW OFTEN DO YOU FLOSS? \_\_\_\_\_ HOW OFTEN DO YOU BRUSH? \_\_\_\_\_

## MEDICAL HISTORY

PHYSICIAN'S NAME \_\_\_\_\_ DATE OF LAST VISIT \_\_\_\_\_

YES  NO HAVE YOU EVER TAKEN ANY OF THE GROUP OF DRUGS COLLECTIVELY REFERRED TO AS "FEN-PHEN?" THESE INCLUDE COMBINATION OF LONIMIN, ADIPEX, FASTIN (BRAND NAMES OF PHENTERMINE), PONDIMIN (FENFLURAMINE) AND REDUX (DEXFENFLURAMINE).

YES  NO HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? IF YES, PLEASE DESCRIBE \_\_\_\_\_

YES  NO HAVE YOU EVER HAD A BLOOD TRANSFUSION? IF YES, GIVE APPROXIMATE DATES \_\_\_\_\_

YES  NO WOMEN, ARE YOU PREGNANT? |  YES  NO NURSING? |  YES  NO TAKING BIRTH CONTROL PILLS?

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> ANEMIA                  | <input type="checkbox"/> CORTISONE TREATMENTS | <input type="checkbox"/> HEPATITIS             | <input type="checkbox"/> SCARLET FEVER              |
| <input type="checkbox"/> ARTHRITIS, RHEUMATISM   | <input type="checkbox"/> COUGH, PERSISTENT    | <input type="checkbox"/> HIGH BLOOD PRESSURE   | <input type="checkbox"/> SHORTNESS OF BREATH        |
| <input type="checkbox"/> ARTIFICIAL HEART VALVES | <input type="checkbox"/> COUGH UP BLOOD       | <input type="checkbox"/> HIV / AIDS            | <input type="checkbox"/> SKIN RASH                  |
| <input type="checkbox"/> ARTIFICIAL JOINTS       | <input type="checkbox"/> DIABETES             | <input type="checkbox"/> JAW PAIN              | <input type="checkbox"/> STROKE                     |
| <input type="checkbox"/> ASTHMA                  | <input type="checkbox"/> EPILEPSY             | <input type="checkbox"/> KIDNEY DISEASE        | <input type="checkbox"/> SWELLING OF FEET OR ANKLES |
| <input type="checkbox"/> BACK PROBLEMS           | <input type="checkbox"/> FAINTING             | <input type="checkbox"/> LIVER DISEASE         | <input type="checkbox"/> THYROID PROBLEMS           |
| <input type="checkbox"/> BLOOD DISEASE           | <input type="checkbox"/> GLAUCOMA             | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> TOBACCO HABIT              |
| <input type="checkbox"/> CANCER                  | <input type="checkbox"/> HEADACHES            | <input type="checkbox"/> PACEMAKER             | <input type="checkbox"/> TONSILLITIS                |
| <input type="checkbox"/> CHEMICAL DEPENDENCY     | <input type="checkbox"/> HEART MURMUR         | <input type="checkbox"/> RADIATION TREATMENT   | <input type="checkbox"/> TUBERCULOSIS               |
| <input type="checkbox"/> CHEMOTHERAPY            | <input type="checkbox"/> HEART PROBLEMS       | <input type="checkbox"/> RESPIRATORY DISEASE   | <input type="checkbox"/> ULCER                      |
| <input type="checkbox"/> CIRCULATORY PROBLEMS    | <input type="checkbox"/> HEMOPHILIA           | <input type="checkbox"/> RHEUMATIC FEVER       | <input type="checkbox"/> VENEREAL DISEASE           |

## MEDICATIONS

DO YOU REQUIRE ANTIBIOTICS BEFORE A DENTAL VISIT? IF YES, PLEASE LIST \_\_\_\_\_

LIST MEDICATIONS YOU ARE CURRENTLY TAKING AND THE CORRELATING DIAGNOSIS \_\_\_\_\_

ALLERGIES \_\_\_\_\_

## OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN. INITIALS \_\_\_\_\_ DATE \_\_\_\_\_

DOCTOR'S COMMENTS \_\_\_\_\_

## MEDICAL HISTORY UPDATE

I HAVE READ MY MEDICAL HISTORY AND CONFIRMED THAT IT STATES PAST AND PRESENT MEDICAL CONDITIONS.

HISTORY UPDATE DATED \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

HISTORY UPDATE DATED \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

HISTORY UPDATE DATED \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

BY EXECUTING THIS AGREEMENT, YOU ARE AGREEING TO PAY FOR ALL SERVICES THAT ARE RECEIVED. **PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

## **INSURANCE**

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THIS CONTRACT, IN MOST CASES. WE WILL BILL YOUR PRIMARY INSURANCE COMPANY AS A COURTESY TO YOU. ALTHOUGH WE MAY ESTIMATE WHAT YOUR INSURANCE COMPANY MAY PAY, IT IS THE INSURANCE COMPANY THAT MAKES THE FINAL DETERMINATION OF YOUR ELIGIBILITY. YOU AGREE TO PAY ANY PORTION OF THE CHARGES NOT COVERED BY INSURANCE. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF TREATMENT OR EXAMINATION RENDERED, TO MY INSURANCE COMPANY.

## **FINANCE CHARGE**

A FINANCE CHARGE WILL BE IMPOSED ON EACH ITEM OF YOUR ACCOUNT THAT HAS NOT BEEN PAID WITHIN NINETY (90) DAYS OF THE TIME THE ITEM WAS ADDED TO THE ACCOUNT. THE **FINANCE CHARGE** WILL BE COMPUTED AT THE RATE OF ONE PERCENT (1%) PER MONTH OR AN **ANNUAL PERCENTAGE RATE** OF TWELVE (12%) PERCENT. THE FINANCE CHARGE ON YOUR ACCOUNT IS COMPUTED BY APPLYING THE PERIODIC RATE (1%) TO THE OVERDUE BALANCE OF YOUR ACCOUNT. TAKING THE BALANCE OWED NINETY (90) DAYS AGO, AND THEN SUBTRACTING ANY PAYMENTS OR CREDITS APPLIED TO THE ACCOUNT DURING THAT TIME CALCULATE THE OVERDUE BALANCE OF YOUR ACCOUNT.

## **COLLECTION FEES AND COSTS**

IF ANY LEGAL ACTION IS NECESSARY TO ENFORCE THE TERMS OF THIS AGREEMENT, OR IF IT IS NECESSARY TO EMPLOY THE SERVICES OF ANY ATTORNEY TO ENFORCE THE TERMS OF THIS AGREEMENT, THE PARTY IN DEFAULT OR IN BREACH HEREOF AGREES TO PAY THE OTHER PARTY'S REASONABLE ATTORNEY'S FEES AND COURT COSTS IN ADDITION TO ANY OTHER RELIEF TO WHICH IT MAY BE ENTITLED IF CUSTOMER FAILS TO PAY ANY AMOUNTS OWING HEREUNDER WHEN DUE, OR OTHERWISE BREACHES ANY TERMS OF THIS AGREEMENT. CUSTOMER AGREES TO PAY UP TO A 50% COLLECTION EXPENSE INCURRED BY EXPRESS RECOVERY SERVICES IN ATTEMPTING TO COLLECT SUCH AMOUNTS FROM CUSTOMER, IN ADDITION TO THE AFOREMENTIONED ATTORNEY'S FEES AND COSTS.

---

PRINT NAME

---

SIGNATURE

---

DATE