APPT TIME _____
ASSISTANT _____
LDV _____ NP/UP

PATIENT INFORMATION

CHART # : _____

PATIENT NAME _____
Last **First** **Middle Initial**

Date of Birth: _____ AGE _____ **GENDER** ☐ Male ☐ Female

Social Security # _____

Phone Numbers HOME: _____ CELL: _____ WORK:_____

ADDRESS _____
Street Apartment #

_____
City State Zip Code

PATIENT HEALTH INFORMATION

Date of last dental visit _____ Reason for this visit _____

Has your child ever had any of the following? Please check YES or NO:

☐YES ☐NO *AIDS*	☐YES ☐NO *Epilepsy*	☐YES ☐NO *Kidney Disease*	☐YES ☐NO *Stomach Problems*
☐YES ☐NO *Allergies*	☐YES ☐NO *Excessive Bleeding*	☐YES ☐NO *Liver Disease*	☐YES ☐NO *Stroke*
_____ _____	☐YES ☐NO *Fainting*	☐YES ☐NO *Mental Disorders*	☐YES ☐NO *Tuberculosis*
_____ _____	☐YES ☐NO *Glaucoma*	☐YES ☐NO *Nervous Disorders*	☐YES ☐NO *Tumors*
☐YES ☐NO *Anemia*	☐YES ☐NO *Growths*	☐YES ☐NO *Pacemaker*	☐YES ☐NO *Ulcers*
☐YES ☐NO *Arthritis*	☐YES ☐NO *Hay Fever*	☐YES ☐NO *Pregnancy*	☐YES ☐NO *Venereal Disease*
☐YES ☐NO *Artificial Joints*	☐YES ☐NO *Head Injuries*	*Due Date:*_____	☐YES ☐NO *Codeine Allergy*
☐YES ☐NO *Asthma*	☐YES ☐NO *Heart Disease*	☐YES ☐NO *Radiation Treatment*	☐YES ☐NO *Penicillin Allergy*
☐YES ☐NO *Blood Disease*	☐YES ☐NO *Heart Murmur*	☐YES ☐NO *Respiratory Problems*	☐YES ☐NO *OTHER:*
☐YES ☐NO *Cancer*	☐YES ☐NO *Hepatitis*	☐YES ☐NO *Rheumatic Fever*	☐ _____
☐YES ☐NO *Diabetes*	☐YES ☐NO *High Blood Pressure*	☐YES ☐NO *Rheumatism*	☐ _____
☐YES ☐NO *Dizziness*	☐YES ☐NO *Jaundice*	☐YES ☐NO *Sinus Problems*	☐ _____

Has your child ever had any complications following dental treatment? ☐ YES ☐ NO

If yes, please explain _____

Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ YES ☐ NO

If yes, please explain _____

Name of Pediatrician/Physician: _____ Phone: _____

Is your child currently under the care of a physician? ☐ YES ☐ NO

If yes, please explain _____

Does your child have any health problems that need further clarification? ☐ 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 patient/child ever has any change in health, I will inform the doctor at the next appointment without fail.

_____ _____
Signature of Parent/Guardian Date

REFFERAL INFORMATION

Whom may we thank for reffering you to our practice? □ Another patient, friend □ Another patient, relative

□ Dental Office □ Pediatrician □ Website □Radio □ Social Media □Other

Name of person reffering you to our practice: _____

_____Dr. Reviewing Medical History

PARENT/GUARDIAN INFORMATION

NAME _____

GENDER □ Male □ Female □ Married □ Single □ Other _____

Date of Birth: _____ Social Security # _____

Phone Numbers HOME: _____ WORK: _____ Ext. ____ Best time to call _____

ADDRESS _____

Street Apartment #

_____

City State Zip Code

Employer Name _____ Occupation _____

Emergency Contact _____ Relationship to Patient _____

Emergency Contact Phone # (Home) _____ (Work) _____

INSURANCE INFORMATION

Primary

NAME OF INSURED _____ SSN# _____

Last First MI

Insured's Date of Birth _____ ID # _____ Group # _____

Insured's Address _____

Street City State

Insured's Employer Name _____

Address _____

Patient's relationship to Insured □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address _____

_____

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 patients 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 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial 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 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 consent. I _____, also give consent for my child _____, to have a dental exam, dental radiographs (x-rays), and a prophylaxis (cleaning).

_____ _____ _____

Signature of Parent Date Relationship to Patient