New Patient Information

Patient Name: ____ **DOB:** ____________ **Date**: _______________
Last First Middle

Phone Numbers: (Cell)_________________(Home)___________________ **Employer:**___________________________

Address:____
Street Apartment#

_________________, __________ __________**Name of DENTAL Ins Company?**_______________________
City State Zip Code

Name of Person Responsible for Payment: _____________________ **Social Security Number:** _______- ______- ______

Do you require Pre-Medication (Antibiotics) before dental treatment? **YES or NO**

Do you have any artificial joints? (Knee Replacement, Hip Replacement, etc**) YES or NO**

Are you currently on a blood thinner? **YES or NO** Do you have High Blood Pressure? **YES or NO**

Are you Pregnant? **YES or NO** (If yes, when is your due date?) **__/___/___**

Are you allergic to anything? **YES or NO** If **yes**, what are you allergic to? _________________________________

Have you ever had surgery? **YES or NO** If **yes**, please list what surgery you have had? _______________________

Please List All Medications you are currently taking. Include the **name, dosage, and reason for taking.**

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Who is your primary care physician? ___________________ **What Pharmacy do you use?** ________________

Have you ever taken- Actonel? **YES or NO** Boniva? **YES or NO** Fosamax? **YES or NO** Reclast? **YES or NO**

Do you currently take- BLOOD THINNERS? **YES or NO** IF YES, WHAT KIND_____________ Daily Aspirin? **YES or NO**

Have you ever had? Head/neck radiation treatment? **YES or NO** Heart attack in the last 6 months? **YES or NO**

Please Check those that apply:

- AIDS/HIV/ Venereal Disease
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Diabetes
- Dizziness
- Epilepsy
- Excessive Bleeding
- Fainting
- Growths
- Hay Fever
- Head Injuries
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Nervous Disorders
- Pacemaker
- Radiation Treatment
- Rheumatic Fever
- Respiratory Problems
- Rheumatism
- Reaction to local anesthetics
- Stomach Problems
- Stroke
- Tuberculosis
- Tumors
- Ulcers
- Codeine Allergy
- Penicillin Allergy
- Thyroid
- Latex Allergy
- Heart Disease

To the best of my knowledge, all 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.

___________________________________ __________
Signature Date

Consent of Disclosure

I hereby give this dental office consent to use and disclose my protected health information for the purposes of treatment, payments, and health care operations. You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf and will be effective the day it is received in our office.

Patient: ____________________ Signature: ____________________

Date: ____________________ Relationship: ____________________

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 filed with the patient's dental insurance and he or she is personally responsible for payment of the estimated patient portion. This office can submit the patient's insurance forms. However, this dental office cannot render services on the assumption that our charges will be paid entirely by an insurance company. **IT IS ULTIMATELY THE PATIENT'S RESPONSIBILITY TO PAY ANY AMOUNT NOT PAID BY AN INSURANCE COMPANY.**

Effective June 1, 2010, if you no-show or fail to give at least 48 hours advance notice (by 10 am Friday for a Monday appointment), we reserve the right to charge you a $25.00 broken appointment fee.

I understand that the fee estimate listed for this dental care can only be extended for a period of two 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 content.

____________________ Date: __________ Relationship to Patient: ____________________
Signature of patient, parent, or guardian

____________________ Date: __________ Relationship to Patient: ____________________
Signature of guarantor of payment/responsible party