

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Preferred Name: _____ Previous Last Name(s): _____
 Male Female Married Single Child Other _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
 Address: _____
Street Apartment #
 _____ Email: _____
City State Zip Code
 Emergency Contact Person (not living with you) _____ Phone # _____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever been treated for any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Artificial Joints/Valves | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | |
| | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors | |

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Date of Last Physical _____ • Are You Taking Medication Now? Yes () No () For What Purpose?

Please List Medications – include vitamins and herbal supplements:

• Do You Use Any Form of Tobacco? _____ If Yes, Are You Interested in Quitting? Yes () No ()

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

• Women: Are You Pregnant? Yes () No () Are You Breastfeeding Yes () No ()
Due Date _____

To the best of my knowledge, all of 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 without fail.

Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? _____

SEE REVERSE SIDE

Responsible Party Information (*guardian present with child at visit today*)

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Previous Last Name(s): _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ Insured's Social Security Number: _____

ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ Insured's Social Security Number: _____

ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a patient of All Smiles Dental, I consent to treatment, financial responsibility, and release of medical information at the time services are rendered. 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, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% 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 collection costs, including reasonable attorney fees if I fail to pay as agreed and my account is turned over to All Smiles Dental's attorney for collection, whether a lawsuit is initiated or not.

Accounts will be turned over to an attorney for collections after 4 past due invoices.

I grant my permission to you or your assignee, to telephone me at home, on my cell, 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: _____