

Patient Information

Patient Name: _____
Gender (M/F): _____ Marital Status: _____ Birth Date: _____ Social Security # _____
Mailing Address: _____
(Street) _____

(City) (State) (Zip Code) Drivers License # _____
Email Address: _____ Billing statements sent to mailing address _____ or email _____
Phone #'s: Home _____ Work _____ Ext _____ Best time to call: _____
Fax _____ Cell _____ Other _____

Spouse or Responsible Party Information

Name: _____
Gender(M/F): _____ Marital Status: _____ Birth Date: _____ Social Security # _____
Driver's License #: _____ E-Mail Address: _____
Address: _____
(Street) _____

(City) (State) (Zip Code)
Phone #'s: Home _____ Work _____ Ext _____ Best time to call: _____
Fax _____ Cell _____ Other _____

Referral Information

Name of person, office or other source referring you to our practice: _____

Employment Information

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

Employer Name: _____ Phone # _____

Address: _____
(Street) (City) (State) (Zip Code)

Insurance Information

Primary:

Name of Insured: _____ Insured's Birth date: _____
Insured's Address: _____
(Street) (City) (State) (Zip Code)
ID# _____ Group # _____
Patient's relationship to insured: __Self __Spouse __Child __Other
Insured's Employer Name: _____
Address: _____
(Street) (City) (State) (Zip Code)
Insurance Plan Name and Address: _____

Secondary:

Name of Insured: _____ Insured's Birth date: _____
Insured's Address: _____
(Street) (City) (State) (Zip Code)
ID# _____ Group # _____
Patient's relationship to insured: __Self __Spouse __Child __Other
Insured's Employer Name: _____
Address: _____
(Street) (City) (State) (Zip Code)
Insurance Plan Name and Address: _____

Medical Information

Patient Name: _____ Date: _____

Have you ever had any of the following? Circle all that apply.

High blood pressure	Mitral valve prolapse	AIDS
Low blood pressure	Kidney problems	Cancer
Heart condition	Dialysis	Radiation treatments
Heart attack	Liver problems	Chemotherapy
Angina	Hepatitis	Wounds that healed slowly
Coronary artery disease	Jaundice	Asthma
Heart surgery	Hemophilia	Tuberculosis
Congestive heart failure	Bleeding problems	Difficulty breathing
Artificial valves	Anemia	Head injury
Irregular beats	Blood transfusion	Epilepsy
Pacemaker	Ulcers	Seizures
Rheumatic fever	Colitis	Fainting spells
Rheumatic heart disease	Diabetes	Severe or frequent headaches
Congenital heart defect	Glaucoma	Psychiatric problems
Heart murmur	Venereal disease	Addiction to drugs or alcohol
	HIV	Artificial bones or joints

Are you currently under a physician's care? YES NO Reason _____

Physician's Name _____ Phone # _____

Address _____

Have you had any major operations? _____

Do you require antibiotic premedication prior to dental treatment? YES NO

Are you currently taking any prescription or non-prescription drugs including aspirin? YES NO

Please list _____

For Women: Are you taking birth control pills? YES NO

Are you pregnant? YES NO

Are you nursing? YES NO

Are you allergic to any of the following?

Aspirin	Sulfa drugs	Tetracycline
Codeine	Sulfur	Dental Anesthesia
Barbiturates	Iodine	Latex
Sedatives	Penicillin	Metal
Sleeping pills	Erythromycin	Other _____

Dental Information

Previous dentist: _____ Phone # _____

Address _____

Last dental exam _____ Last dental x-rays _____

Chief dental complaint: _____

Do you ever have pain in your jaw (TMJ/TMD)? YES NO

Does your jaw click or pop? YES NO

Do you habitually clench or grind your teeth? YES NO

Do you have any unhealed injuries or inflamed areas in or around your mouth? YES NO

Do you have any growths or sore spots in your mouth? YES NO

Have you ever had any difficulties with previous dental treatment? YES NO

Do your gums bleed? YES NO

Do you chew on one side of your mouth? YES NO

Is any part of your mouth sore to pressure, cold, sweets, hot chewing, other? YES NO

Do you smoke? YES NO

Consent: As the undersigned, I hereby authorize the Doctor, after thorough explanation, to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated (after they are discussed with me) and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine, due and payable at the time services are rendered. I also understand that finance charges may begin to accrue on unpaid balances. Also, collection fees may be added to any outstanding accounts.

FINANCIAL POLICY

We at Dynamic Modern Dentistry are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition we are also dedicated to making top-quality care as cost-effective as possible. To assist you with your healthcare investment, we provide the following payment options:

Payment Options

1. Cash --- includes money orders and personal checks.
2. Credit Cards --- We accept all major credit cards.
3. Payment Plans --- We have an outside agency that offers payment options.

We are happy to offer these payment options. We are please you have chosen to become a member of our family.

Signature of patient, parent, or responsible party

Date

Reviewers signature

Date

