PATIENT INFORMATION SHEET

Patient Name
(Dr.Rev.Mr.Mrs.Ms.) First _____ M._____ **Last** _____

(Preferred Name/or nickname)_____ Drivers License #_____

Address_____ City_____ State_____ Zip____

HomeTel:(___)_____ **Bus.Tel:**(___)_____ **Cell:**_____

S.S._____ **Email address:**_____

M:/F:_____ Birthday____/____/_____ Age:_____ Marital Status: _____

Student: Yes_____ No___ Full time: Yes ____ No____ Where:_____

Employed by:_____ Spouse Name_____

Spouse Employed by:_____ Bus:Tel:_____

If Minor – Parent or Guardian Name:_____

Mailing Address:_____ City_____ State_____ Zip_____

Home Tel:_____ Business Tel:_____

Patient/Parent Employed by:_____ Bus:Tel:_____

Responsible Party (Circle) Self Spouse Parent Guardian Other:_____

Referred by:_____

INSURANCE: Circle: Primary: Yes No Secondary: Yes No

Policy Holder's Name:_____ Employed by:_____

Insurance Company Name:_____ Group#_____

Birthday:_____ Subscriber #_____ S.S._____

Patients relationship to Insured: (Circle) Self Spouse Child other

In order to consult with specialists or your physician as needed, and to file insurance (if applicable) I hereby authorize the office to release information acquired in the course of my exam and treatment.

Signature:_____ Date:_____

MEDICAL HISTORY

DATE OF LAST DENTAL VISIT:_____

Does Your Medical History Include Any of The Following: Yes or No

Have you had any dental problems since your last visit? ____

Are you currently under the care of a physician? _____

Have you recently been hospitalized or had surgery? _____

Have you had prolonged bleeding after surgery or extractions? ____

Are you taking any blood thinners? _____

Do you have high blood pressure? _____

Have you had rheumatic fever or any heart disease or murmur? _____

Have you had any problems w/liver, hepatitis, or alcoholism? _____

Do you have epilepsy or seizures? _____

Women—Are you pregnant or using oral contraceptives? _____

Do you have any prosthesis(artificial joints, valves, etc)? _____

Have you ever had cancer, radiotherapy, or chemotherapy? _____

Do you have asthma or breathing problems? _____

Have you tested for HIV or had immune deficiency problems? _____

List Drugs You Are Presently Taking:_____

_____

Are you Allergic to any drugs or medications:_____

_____

In Case Of Emergency, Notify: & Phone# _____

_____

Patient or Guardian Signature Date

FINANCIAL POLICY

WE VALUE OUR RELATIONSHIPS WITH OUR PATIENTS. If ever you have questions regarding fees or treatment, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding and preserve a friendship.

Our objective is to provide optimum oral health care with efficiency, enthusiasm, and gentleness. The following is our policy on methods of payment:

1. You may pay by (check one or more):

   A. **Cash** _____

   B. **Check** _____

   C. **Credit card** _____

   Our office offers a 5% bookkeeping allowance on operative treatment fees over $100 if paid in full by cash or check on the day of treatment.

2. For our patients with **Dental Insurance:** Please remember that you, not your insurance company, are responsible for payment of professional service. As a courtesy to you we will prepare your insurance claim forms. We do not, however, accept responsibility for collecting your claim, negotiating a settlement, or resolving a disputed claim. Your deductible, co-payment, and non-covered service fees are due at time of treatment. You will need to assign benefits to this office for all services rendered unless paid at that time.

3. Do you have a flex account? _____yes _____no

*******ALL LABORATORY PROCEDURES*******
Regardless of dental insurance
50% is due on the date treatment begins.

4. There will be a finance charge of 1.25% / month on any unpaid balance over 60 days.

I ACCEPT RESPONSIBILITY FOR PAYMENT ON THIS ACCOUNT.

Signed_____ Date_____
by patient or guardian