GREENWAY
DENTAL EXCELLENCE

Input _____
Scanned _____

PATIENT INFORMATION

Chart #: _____

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Driver's License # _____ Gender: _____ E-Mail _____

Social Security #: _____ Birth Date: _____ Cell Phone # _____

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

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

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

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 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 30 days, unless previously written financial arrangements are satisfied and a 30.00 late fee charge if my account becomes delinquent.
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 my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I understand and agree to a $40.00 charge, which I am solely responsible for when I fail to give at least 24 Hrs advance notice of appointment cancellation and a $40.00 when my account becomes past due. (accounts are due upon statement received)

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

Spouse or Responsible Party Information

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

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

In case of emergency please notify: _____
Name Phone # Relation

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Kurt J Greenway DDS
3679 Arlington Ave. Riverside CA 92506

Chart #

DENTAL HISTORY
PATIENT NAME:

Date of last dental x-rays_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Periodontal treatment	☐ Yes	☐ No	Blisters on lips or mouth	☐ Yes	☐ No
Sensitivity to hot	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No	Clicking or popping jaw	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No	Dry mouth	☐ Yes	☐ No
Chronic Bad Breath	☐ Yes	☐ No	Fingernail chewing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Food collection between teeth	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No
			Gums Swollen or tender	☐ Yes	☐ No
			Jaw pain or tenderness	☐ Yes	☐ No
			Lip or cheek biting	☐ Yes	☐ No
			Loose tth. Or broken fillings	☐ Yes	☐ No
			Mouth breathing	☐ Yes	☐ No
			Mouth pain upon brushing	☐ Yes	☐ No
			Orthodontic treatment	☐ Yes	☐ No
			Pain around ear	☐ Yes	☐ No

Health History

Physician's Name & Hospital_____ Date of last visit_____

AIDS	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Anemia	☐ yes	☐ No	Epilepsy	☐ Yes	☐ No	Nervous Disorders	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Fibromylagia	☐ Yes	☐ No	Phen-fen	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Abnormal bleeding	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis type_____	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Congenital Heart Problems	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cough, persistent/bloody	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tumors/Growths	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Drugs: Recreational	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
			Low Blood Pressure	☐ Yes	☐ No	Pregnant	☐ Yes	☐ No
						Birth Control	☐ Yes	☐ No

MEDICATIONS

List medications you are currently taking:

ALLERGIES ☐ yes ☐ no

Aspirin	☐	Latex	☐
Barbiturates	☐	Local Anesthetic	☐
Codeine	☐	Penicillin	☐
Iodine	☐	Sulfa	☐

☐ Other_____

The information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status or insurance coverage. I authorize the dental staff to perform necessary dental services that I may need during the diagnosis and treatment of my dental condition.

Patient or Parent Signature_____

Doctor Signature_____ **Date**_____

(Year 2 Changes)_____

Pt.Signature_____ **Date**_____**Dr.**_____

BP_____/_____

PULSE _____

BP _____/_____

PULSE _____