PATIENT INFORMATION

Name_____ **Preferred Name** _____

Last First Middle Initial

_____

Street Apt# City State Zip

Date of Birth _____ **Male** _ **Female** _ / **Single** _ **Married**_ **Divorced**_ **Other** _

Phone (Home)_____ **(Cell)**_____ **(Work)**_____

Social Security #_____ **Email** _____

Emergency Contact _____ **Phone** _____

Patient's Employer _____

How did you hear about us? Internet _ **Walk in**_**Co-Worker/Friend** _ **Referred by:** _____

Previous Dentist_____ **When was your last dental visit?** _____

INSURANCE INFORMATION

Primary Dental- Insurance Co., Name_____ **Phone #**_____

Insured's Name _____ **DOB**_____ **ID#** _____

Insured's Employer _____ **Group #**_____

Relationship to Patient _____

Secondary Dental- Insurance Co., Name_____ **Phone #**_____

Insured's Name _____ **DOB**_____ **ID#** _____

Insured's Employer _____ **Group #**_____

Relationship to Patient _____

MEDICAL INFORMATION

Physician's Name _____ ___ Phone_____

Have you had a serious illness or operation Y__ N__

If yes, please describe _____

Are you currently under a physician's care Y__N__

If yes, please describe _____

Please list any medications you are currently taking_____

Do you smoke? Y__ N__ If yes, how often?_____ Do you used any tobacco products? Y__ N__

**** DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING ****

	Y / N		Y / N		Y / N
Rheumatic Fever	___ ___	Arthritis	__ __	**ALLERGIES TO:**	__ __
Heart Trouble	___ ___	Asthma	__ __	Penicillin	__ __
Heart Attack	__ __	Hay Fever	__ __	Other Antibiotics	__ __
Heart Murmur	__ __	Tuberculosis	__ __	_____	
High Blood Pressure	__ __	Hepatitis	__ __	Novocaine	__ __
Low Blood Pressure	__ __	Jaundice	__ __	Other Anesthetics	__ __
Blood Disorders	__ __	Fainting Spells	__ __	_____	
Abnormal Bleeding	__ __	Seizures	__ __	Aspirin	__ __
Anemia	__ __	Diabetes	__ __	Codeine	__ __
Radiation Txmt	__ __	Hypoglycemia	__ __	Other Allergies	__ __
Severe Headaches	__ __	Stroke	__ __	_____	
Sinus Problems	__ __	Cancer	__ __		
Night Sweats	__ __	Joints Replaced	__ __		
HIV Exposure	__ __	Venereal Disease	__ __		
		Aids	__ __		

****WOMEN ONLY****

Birth Control Pills Y / N

Pregnant? Y / N If yes, Due Date _____

What is your main dental concern today?

____Overall good health and dental health maintenance

____ Taking care of current problem only

Is there anything you would like to change about your teeth?_____

Are there any specific questions that you would like us to answer today? _____

Missed Appointment Policy

If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hrs., in advance. We enforce a missed appointment policy to ensure that other patients receive care in a timely manner. Missed appointments and appointments cancelled without a 24 hour notice are subject to a cancellation fee of **$25 per hour of the scheduled appointment time.**

TREATMENT PLAN QUOTES ARE HONORED FOR 60 DAYS FROM DATE OF TREATMENT PLAN PRESENTATION

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for me and my family shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In the event legal action should be necessary to collect an unpaid balance for dental services rendered, I agree to pay reasonable attorney's fees or other such costs as the court determines proper. It is agreed that the payments will not be delayed or withheld because of insurance coverage or the pendency of claims thereon and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof (*A copy of this agreement is as valid as the original).*

NOTICE: Do Not Sign this agreement before you read and agree to the conditional set for herein. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights. Agreement: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I agree to pay interest charges at a rate of 1 1/2% mth., on all balances over **60 days**.

This information above is correct to the best of my knowledge.

_____ _____

Patient or Parent/Guardian (If under 18 yrs. Of age) Signature

Date

*****FOR DOCTORS USE ONLY *****

Ck Medical Dr. _____ Rev. Dr. _____ Rev. Dr. _____ Rev. Dr._____

Date _____ Date _____ Date _____ Date _____