UPDATED PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ **Date:** _____

Address: _____ **City / State / Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Ext.:** _____ **Cell Phone:** _____

Employer: _____ **Emergency Contact:** _____ **Phone:** _____ **SSC#:** _____

INSURANCE

Insurance Company: _____ **Group #1:** _____

Subscriber's Name: _____ **SSN #1:** _____

Employer: _____

Claim Address: _____ **City / State / Zip:** _____ **Phone:** _____

MEDICAL HISTORY

Are you under a physician's care now? Why? _____

Are you taking any medications, pills or drugs? Why? _____

Have you ever or are taking diet pills? If so, what? _____

Are you allergic to any medications or substances? Check: ☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC ☐ METAL ☐ LATEX RUBBER **OTHER:** _____

WOMEN ONLY - Check: ☐ PREGNANT ☐ TRYING TO GET PREGNANT ☐ NURSING ☐ TAKING ORAL CONTRACEPTIVES

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	JOINT REPLACEMENT PROSTHESIS*	☐	☐	HEMOPHILIA	☐	☐	ALLERGIES (MEDICATIONS)	☐	☐	BLOOD DISEASE
☐	☐	HEART MURMUR*	☐	☐	LUKEMIA	☐	☐	ALLERGIES (POLLEN/DUST)	☐	☐	EXCESSIVE BLEEDING
☐	☐	MITRAL VALVE PROLAPSE*	☐	☐	CANCER	☐	☐	ANEMIA	☐	☐	ALZHIEMER'S DIESEASE
☐	☐	RHEUMATIC FEVER*	☐	☐	CHEMOTHERAPY	☐	☐	ARTHRITIS	☐	☐	HERPES
☐	☐	HEART PACE MAKER*	☐	☐	DIABETES	☐	☐	ASTHMA	☐	☐	STROKE
☐	☐	ARTIFICIAL HEART VALVE*	☐	☐	HEPATITIS A (INFECTION)	☐	☐	BLOOD TRANSFUSION	☐	☐	PULMONARY DISEASE
☐	☐	HEART SURGERY*	☐	☐	HEPATITIS B OR C	☐	☐	ANGINA	☐	☐	SYSTEMATIC LUPUS
☐	☐	HEART ATTACK.FAILURE	☐	☐	PAIN IN JAW JOINTS	☐	☐	EMPHYSEMA	☐	☐	TUBERCULOSIS
☐	☐	CONGENITAL HEART DISORDER	☐	☐	AIDS	☐	☐	EPILEPSY	☐	☐	HEARING IMPAIRMENT
☐	☐	HEART TROUBLE	☐	☐	HIV POSITIVE	☐	☐	FAINTING SPELL			
☐	☐	HIGH BLOOD PRESSURE	☐	☐	COLD SORES	☐	☐	SEIZURES			
☐	☐	LOW BLOOD PRESSURE	☐	☐	FEVER BLISTERS	☐	☐	OSTEOPOROSIS			

**If you answered YES to any of the starred conditions, please call prior to appointment. Pre-medication may be required.*

Are you mentally or physically handicapped? ☐ **YES** ☐ **NO**

Have you ever had any other serious illness not checked above? ☐ **YES** ☐ **NO**

Have you had any surgery? ☐ **YES** ☐ **NO** **If YES, what year?** _____ **Type of surgery?** _____

Do you wish to talk to the dentist privately about any problems? ☐ **YES** ☐ **NO**

CONSENT

I will answer all health questions to the best of my knowledge. *Please initial:* _____

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decided in order to carry out these procedures. I also authorize and request the administration of anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature: _____ **Date:** _____ **Relationship to Patient:** _____

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this office the benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you. I agree that in the event this office or I institute any legal proceedings with respect to amounts owed by me for serves rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or to your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signature: _____ **Date:** _____