Patient Information									
Patient Name:			Date:						
Address:	Last	First	MI	Preferred					
7.dd. c55	Street				Apartment #				
	City		State		Zip Code				
Employer:				Occupati	on:				
Family Status:	Family Status: ☐ Married ☐ Divorced ☐ Single ☐ Child ☐ Other:								
Social Security #:		Birth Date: Gender: ☐ Male ☐ Female		_ Gender: □ Male □ Female					
Phone:	none:								
Please check number to be used for appointment reminders Email Address:									
Emergency Conta	ict Name		Phone		Relationship				
I agree to receive	emails from the	practice ☐ Yes ☐ No							
Spouse, Parent, or Responsible Party Information The following is for:									
Phone: Home		Work		ext	Cell:				
Address:									
		Insura	nce Informat	ion					
Name:	Name: Is subscriber a patient? ☐ Yes ☐ No								
Subscriber Birth [Subscriber Birth Date: Social Security #: Group#								
Subscriber's Address:									
Subscriber's Employer/Address:									
Patient Relations	hip to Subscriber	: □ Self □ Spo	use 🗆 Child	☐ Other					
Insurance Co Nan	ne Insurance Co Phone								
Insurance Co Address									
		Consent for S	ervices (Read	d Carefully)					
Consent for Services (Read Carefully) 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 the 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 1	A service charge of 1 1/2 % per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written inancial arrangements are satisfied.								
_	I understand that the fee estimate listed for this dental care can only be extended for a period of 30 days from the date of the patient examination.								
I grant my permission to you or your assignee, to telephone me at home or my work or cell to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.									
				Relationsh	nip to Patient				
Signature of Patient, Pa	rent, or Guardian	Date:		Relationsh	nip to Patient				
Signture of Guarnator of	Payment/Responsible F	Party							
How did you hear about our practice? ☐ Friend, relative, neighbor, etc. ☐ Another dentist ☐ Post Card ☐ Mailbox Flyer ☐ Internet ☐ Sign/Drive-by So we may thank them, please provide name of person or dentist who referred you:									

MEDICAL HISTORY	Patient Name:	Date:			
Please check all of the medica	I conditions/situations that apply to y	ou.			
 ☐ Heart Surgery ☐ Heart Disease ☐ Heart Attack ☐ Chest Pain ☐ Congenital Heart Disease ☐ Heart Murmur ☐ High Blood Pressure ☐ Mitral Valve Prolapse ☐ Artificial Heart Valve ☐ Heart Stent/Shunt ☐ Heart Pacemaker ☐ Sleep Apnea ☐ Rheumatic Fever ☐ Arthritis/Rheumatism 	☐ Stroke☐ High Cholesterol☐ Kidney Trouble☐ Kidney Stent/Shunt	☐ Tuberculosis ☐ Asthma ☐ Hay Fever ☐ Sinus Trouble ☐ Allergies or Hives ☐ Latex Sensitivity ☐ Liver Disease	□ AIDS □ Blood Transfusion □ Blood Thinners □ Hemophilia □ Sickle Cell Disease □ Neurological Disorder □ Epilepsy or Seizures □ Fainting or Dizzy Spells □ Nervous/Anxious □ Psychiatric Care □ TMJ Disorder □ Smoke/Chew/Vape Tobacco □ Jaw/Ear Pain		
Do you have any artificial join	ts? □ No □ Yes → Please tell us whi	ch joint(s) and what year you go	ot it/them		
Name of Physician Are you taking any medication	nysician? □ No □ Yes → Please explan, drugs, or pills now? □ No □ Yes	⇒Please list			
What is the reason for your v	sit today?				
Date of Last Cleaning?		Date of Last Full Set of X-Rays?	?		
Have you ever been diagnose	d with periodontal "gum" disease? □	l No □ Yes → Date of treat	ment		
What is your goal in seeking o ☐ Prevent problems	ental care? Please check all that appl	☐ Fix cosmetic problems	☐ Resolve pain only		
	□ No □ Yes → Months A control pills? □ No □ Yes	re you nursing? ☐ No ☐ Yes			
	Doct	or Signature:	<u>-</u>		
all questions to the best of my provider or agency who may re hereby authorize the doctor of appropriate by the doctor to re diagnosis, I authorize the doctor as required to provide proper	tion above is necessary to provide me knowledge. Should further informati elease such information to you. I will or designated staff to take x-rays, stud- make a thorough diagnosis of for to perform all recommended treat care. I agree to the use of anesthetics mbodies certain risks; I understand the	ion be needed, you have my per notify the doctor of any change y models, photographs, and any (Patient ment mutual agreed upon by m s, sedatives, and other medication	rmission to ask the respective care in my health or medication. I other diagnostic aids deemed Name)'s dental needs. Upon such he and to employ such assistance on necessary. I fully understand		
Patient	<u>Date</u>	Witness			
Dagagaible Dagby					



Medical Information Release Form (HIPAA Release Form)

Name:	Date of Birth://
Release o	of Information
☐ I authorize the release of information rendered to me and claims information.	n including the diagnosis, records, examination
☐ Spouse	
☐ Child(ren)	
□ Other(s)	
☐ Information is not to be released to	anyone.
This Release of information will remain i	n effect until terminated by me in writing.
<u>Me</u>	<u>ssages</u>
Please call □ my home □ my work	x □ my cell number:
If unable to reach me:	
□ you may leave a detailed message□ leave a message asking me to retu□ Other instruction:	•
The best time to reach me is (day)	between (time)
Signed:	Date:/
Witness:	Date: / /