New Patient Information Form

Patient Information

Patient's Name: _____ Date: _____

Address: _____

Street _____ Apt #

City State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Social Security #: _____ Marital Status: _____

Birthdate: _____ Gender: M F

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____

Street Phone

City State Zip Code

If full-time student, name of school: _____

Patient Health Information

Date of last dental visit _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
☐ Allergies	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Hay Fever	☐ Pregnancy:	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due Date:_____	☐ Codeine Allergy
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	☐ Current Medications
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	_____
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism	_____
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	_____
☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems	_____
☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke	_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physcian? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physcian: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

if yes, please explain: _____

Person to contact in case of emergency: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Spouse or Responsible Party Information

Name: _____

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child Other _____

Social Security #: _____ _____ Birthdate: _____

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

Address: _____
Street Apt#

_____
City State Zip Code

Insurance Information

Primary Insurance:

Name of insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's birthdate: _____ ID#: _____ Group #: _____

Insured's address: _____
Street City State Zip Code

Insured's employer name: _____

Employer address: _____
Street City State Zip Code

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

Insurance company name: _____

Insurance company address: _____

Secondary Insurance:

Name of insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's birthdate: _____ ID#: _____ Group: _____

Insured's address: _____
Street City State Zip Code

Insured's employer name: _____

Employer address: _____
Street City State Zip Code

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

Insurance plan name and address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advanced. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsbility 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 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 breech 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 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