Patient Information

Patient Name: ____ Date__________
Last, First MI (Preferred Name)

Gender:______Family Status: _____**Social Security #:** ____________________**Birth Date:** _______________

Phone (Home): _______________ (Work): _______________ Ext: _______ Best time to call: _____________

Cell Phone: _____________________ **Email:** ____________________________@______________________

Address:

____

Emergency Contact: Name & Phone #

Health Information

Have you ever had any of the following? This is important information! Please carefully check those that apply:

- ☐ Acid Reflux /GERD
- ☐ AIDS/HIV
- ☐ Allergies __________ __________
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfur Drug Allergy
- ☐ OTHER DRUGS: ____________________ ____________________
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer Type: ____________
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Depression
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fen-Phen, Redux, etc.
- ☐ Fosamax, Actonel, Boniva, Reclast, Prolia
- ☐ Glaucoma
- ☐ Growths or Tumors

- ☐ Hay Fever/Sinusitis
- ☐ Head Injuries
- ☐ Heart Disease/Attack
- ☐ Heart Murmur/ Irregular Heart Beat
- ☐ Heart Valve
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Immunosuppression
- ☐ Joint Replacement ____________________
- ☐ Kidney Disease/Stone
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker/ Defibrillator
- ☐ If Pregnant, Due date: ____________

- ☐ Previous Bacterial Endocarditis
- ☐ Radiation Treatment
- ☐ Reaction to Anesthesia Type: _______________
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tobacco Use How often: _______ ________________
- ☐ Transplant
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Please List All Current Medications / Herbal Supplements:

____
____
____
____
____
____
____
____
____

- **Have you ever had heart trouble or high blood pressure?** ☐ **Yes** ☐ **No**
  If yes, please explain:____
- **Have you ever been advised to take antibiotics before dental treatment?** ☐ **Yes** ☐ **No**
  If yes, please explain:____
- **Have you ever had excessive bleeding after extractions or cuts?** ☐ **Yes** ☐ **No**
  If yes, please explain:____
- **Have you ever had a reaction to any drugs or medication?** ☐ **Yes** ☐ **No**
  If yes, please list & explain:____
- **Have you ever had a serious illness or condition?** ☐ **Yes** ☐ **No**
  If yes, please explain:____
- **Have you ever had any complications following dental treatment?** ☐ **Yes** ☐ **No**
  If yes, please explain:____
- **Have you been admitted to a hospital or needed surgery or emergency care during the past two years?**
  ☐ **Yes** ☐ **No**
  If yes, please explain: ____

- **Are you now under the care of a physician?** ☐ **Yes** ☐ **No**
  If yes, please explain:______________________________
- Name of Physician: ______________________________ Phone:__________________
- **Do you have any health problems that need further clarification?** ☐ **Yes** ☐ **No**
  If yes, please explain:______________________________

PLEASE INQUIRE ABOUT ANY QUESTIONS THAT ARE NOT UNDERSTOOD!
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 doctors at the next appointment without fail.

Insured 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

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 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.

I understand that if my account becomes delinquent it will be placed with a collection agency. Further, I agree to the following terms regarding any outstanding balance I owe: (1.) I will incur interest at the rate of 1&1/2 percent per month (18% per annum); (2.) I agree and hereby consent that I will be responsible for reasonable collection costs and attorney's fees in the amount of 33 1/3 %, in addition to the outstanding balance, and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgement has been issued in a lawsuit; and (3.) I agree and hereby consent that any lawsuit and/or legal preceding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, AL, and I hereby waive any and all defenses and/or objections to said jurisdiction and waive are rights to claim exemption. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy I understand my credit history will be investigated and thoroughly reviewed.

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