Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI

Preferred Name: _____ Previous Last Name(s): _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell):_____

Address: _____
Street Apartment #

_____ Email:_____
City State Zip Code

Emergency Contact Person (not living with you) _____ Phone # _____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit:_____

Have you ever been treated for any of the following? Please check those that apply:

☐ AIDS/HIV Positive
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints/Valves
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Seasonal Allergies
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Date of Last Physical _____ • Are You Taking Medication Now? Yes ☐ No ☐ For What Purpose?

Please List Medications – include vitamins and herbal supplements:

- Do You Use Any Form of Tobacco?_____ If Yes, Are You Interested in Quitting? Yes ☐ No ☐
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

•Women: Are You Pregnant? Yes ☐ No ☐ Are You Breastfeeding Yes ☐ No ☐
Due Date_____

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.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? _____

SEE REVERSE SIDE

Responsible Party Information (*guardian present with child at visit today*)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Previous Last Name(s): _____

Social Security #: _____ Birth Date: _____

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

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

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

Last First MI

Insured's Birth Date: _____ Insured's Social Security Number: _____

ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

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

Last First MI

Insured's Birth Date: _____ Insured's Social Security Number: _____

ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a patient of All Smiles Dental, I consent to treatment, financial responsibility, and release of medical information at the time services are rendered. 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.

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 breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all collection costs, including reasonable attorney fees if I fail to pay as agreed and my account is turned over to All Smiles Dental's attorney for collection, whether a lawsuit is initiated or not.

Accounts will be turned over to an attorney for collections after 4 past due invoices.

I grant my permission to you or your assignee, to telephone me at home, on my cell, 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