



PATIENT INFORMATION:

Patient Name: _____ Date: _____

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

Circle one: ☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Circle One: ☐ Married ☐ Single ☐ Other ☐ Child

Phone Number(s): _____

Emergency Contact Person & Ph: _____

Home Address: _____

Email: _____ Preferred Pharmacy: _____

HEALTH INFORMATION:

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

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

(new patients) Date of Last Dental Visit: _____

Have you ever had any complications following dental treatment? _____

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Date of last physical: _____ Are you taking medications? _____

Please list all medications (including vitamins and herbal supplements): _____

Do you use tobacco? _____ Any other health problems that need clarification? If yes, please explain: _____

Women: Are you pregnant: _____ Due Date: _____ Breastfeeding? _____

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.

Signature of patient/parent/guardian: _____

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

Name: _____ Circle One ☐ Married ☐ Single ☐ Other

Circle one: ☐ Male ☐ Female

Previous Last Name(s): _____ Social Security #: _____

Phone Number(s): _____ Relationship to patient: _____

Address: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____ Phone: _____

Insurance Information

Primary Insurance:

Name of Insured: _____ Is insured a patient? _____

Patient's relationship to insured: _____

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

Name of Insurance Company: _____ Ph: _____

Member ID#: _____ Group#: _____

Secondary Insurance:

Name of Insured: _____ Is insured a patient? _____

Patient's relationship to insured: _____

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

Name of Insurance Company: _____ Ph: _____

Member ID #: _____ Group#: _____

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 our treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost 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 patient's 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 service on the assumption that our charges will be paid by an insurance company.

A service charge of 1/2% 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 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, as 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 your assignee, to telephone me at home, or my cell, or my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signature of Patient/Parent/Guardian: _____ Date: _____