

PATIENT INFORMATION FORM

PATIENT INFORMATION

Name _____

Address _____ City _____ State _____ Zip _____

Sex: M F Date of Birth ____/____/____ School _____

PERSON RESPONSIBLE FOR ACCOUNT

Title: Mr. Mrs. Ms. Miss Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occ. _____ Work Phone _____

Spouse's Name _____ Employer _____

Work Phone _____ Soc. Sec. # _____

DENTAL INSURANCE INFORMATION

Employer _____ Insurance Company Name _____

Contract # _____ Policyholder's Name _____

Soc. Sec. # _____ Date of Birth ____/____/____

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

MEDICAL HISTORY

Medical Doctor's Name _____ Date of last physical exam _____

Are you currently under your physician's care? _____ For what? _____

Women: Are you pregnant? _____ Due date _____

What medication, pills, or drugs are you taking? _____

Have you been hospitalized in the last two years? _____ Why? _____

Have you ever had any of the following? (please circle)

| | | | | |
|--------------|-------------------------|---------------------|-----------------------|-----------|
| Heart murmur | Congenital heart defect | Breathing disorders | Mitral valve prolapse | Hepatitis |
| Epilepsy | Rheumatic fever | Diabetes | Cancer | Aids |

Do you have any allergies to drugs, medications, or anesthetics? Please list _____

METHOD OF PAYMENT

_____ Fees for dental hygiene care and basic services are due at the time treatment is rendered at a 5% savings.

_____ VISA or MasterCard

_____ Payment due in full upon receiving monthly statement.

_____ Financial arrangements on approval.

Regarding dental insurance: It is important that we inform you that our services are charged to the patient, not an insurance company. Dental insurance pays only a portion of your investment, and we urge you to be aware of the provisions of your policy. *Co-pay and deductibles due day of appointment.*

The finance charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance.

AUTHORIZATION

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

I hereby agree to the above terms. Parent's Signature _____ Date _____