Name **DOB** **M/F**

Social Security# **Email Address**

Cell Phone **Home Phone** **Work Phone**

Address

City **State.** **ZIP Code**

Occupation/ Employer

Dental Insurance **Subscriber on Dental Insurance**

Subscriber Date of Birth **Subscriber SS#**

Spouse Name **Spouse cell #**

Signature **Date**

CONSENT

•I will answer all health questions to the best of my knowledge**:** **Initial** _____
After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____
Signature Date: Relationship to Patient

TERMS AND CONDITIONS
This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.
Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. Iunderstand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. 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 and agree to their content.

Signed_____ **Date**_____

There is a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

Name:_____

Medical Conditions: _____

Please list all Medications: _____

Y N Do you need to Pre-Medicate with an antibiotic before dental treatment?

Y N Allergies to Medications please list: _____

Y N Do you take Blood Thinners, Anticoagulants, Aspirin, or Baby Aspirin Daily? _____

Y N Do you have a history of prolonged Bleeding Disorder?

Y N Do you take Osteoporosis Medication?

Y N Have you had a Joint replaced? _____

Y N Have you had any adverse reaction to Epinephrine? _____

Y N Do you have a heart condition? _____

Y N Have you had any heart surgeries? _____

Explain: _____

Y N Do you have or had Cancer? _____ **Chemo?** _____ **Radiation?** _____

if yes: Has your oncologist cleared you for dental work? _____

Emergency Contact: Name_____ **Relationship**_____**Phone**_____

Physician's Name: _____**Phone**_____

Please explain reason for today's visit_____

Previous Dentist: _____ **Last Visit**_____

How often do you brush your teeth? _____ **How often do you floss?** _____

Y N Do your gums bleed when you Brush?

Y N Do you avoid brushing an area of your mouth? _____

Y N Do you have Dry mouth?

Y N Do you grind or Clench your teeth? _____ **Jaw Pain?** _____

Y N Are you happy with your smile?

Y N Have you had orthodontics? _____

Signature: _____**Date:**_____