

Patient Information

Patient Name _____ **Date:** _____
Last, First MI (Preferred Name)
 Name of Parents' if Minor- _____ **Patient Gender:** Male/Female (circle)
Marital Status: Mr./ Mrs./ Single/ Widowed/ (Please circle)
Patient Social Security #: _____ **Patient Birth Date:** _____
Phone Home: _____ **Work:** _____ **(Responsible parent) Ext:** _____
Cell: _____ **E-mail Address** _____ **Other:** _____
Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ **Reason for this visit:** _____
Are you interested in any of these dental treatments? _____ **Invisalign** _____ **Cosmetic Veneers** _____ **Whitening** _____ **Sedation Dentistry**

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> Drug Treatment | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcohol Treatment | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors of Growths |
| <input type="checkbox"/> Artificial | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ulcers |
| Joints/Skeletal | <input type="checkbox"/> Growths | Due date: _____ | <input type="checkbox"/> Venereal Disease |
| Implants, Valves | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Aches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Anesthesia Allergies |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Latex Allergies |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Metal Allergies |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Allergies Other |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | (unexplained) |
| <input type="checkbox"/> Cough, Bloody | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Special Diet | |
| | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke | |

- **Have you ever had any complications following dental treatment?** Yes No
 If yes, please explain: _____
- **Have you been admitted to a hospital or needed emergency care during the past two years?** Yes No
 If yes, please explain: _____
- **Are you now under the care of a physician?** Yes No • **Name of Physician:** _____ **Phone:** _____
 If yes, please explain: _____
- **Are you allergic to any medications** Yes No _____
- **Are you taking a blood thinner such as Warfarin, Coumadin, etc. ?** Yes No _____
- **Are you presently taking a medication for soft bone such as Osteoporosis, Fosamax, etc.?** Yes No _____
- **Are you currently taking any medications? If yes, please list:** _____
- **Do you have any health problems that need further clarification?** Yes No
 If yes, please explain: _____
- **Do you have a prosthetic implant?** Yes No _____

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- Patient, Parent, Guardian

Sunshine Dentists

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Responsible 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- _____

Home Phone- _____ Work phone- _____ Ext. _____

Employer Name _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Street Apartment #

City State Zip Code

Spouses Information

Name _____

Male Female

Social Security# _____ Birth Date- _____

Home Phone- _____ Work phone- _____ Ext. _____

Employer Name _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Street Apartment #

City State Zip Code

Insurance Information

Primary Insurance Information

Name of Insured: _____ Is insured a patient? YES NO

Patient's relationship to insured: Self Spouse Child Other- _____

Insurance Plan Name and Address: _____

Insured's Birth-date Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Employer Address- _____

Secondary Insurance Information

Name of Insured: _____ Is insured a patient? YES NO

Patient's relationship to insured: Self Spouse Child Other- _____

Insurance Plan Name and Address: _____

Insured's Birth-date Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Employer Address- _____

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.

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 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 costs and reasonable attorney fees if suit be instituted hereunder.

Your appointment times are reserved just for you. If you are unable to keep your appointment, please let us know 24 hrs in advance so that we may schedule a new time for you. A fee of \$25 will be assessed for failure to keep scheduled appointments.

I understand that in the event my account becomes delinquent I agree to pay any and all collection, attorney's and court costs necessary to clear this account balance.

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/responsible party

This patient's health history has been reviewed. Drs. Signature- _____ Date- _____