PATIENT INFORMATION

Date _____

Patient's Name _____ Age _____ Birthday _____ ☐ Male ☐ Female
LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Address _____ How Long? _____ ☐ ☐
STREET CITY ZIP

Patient is ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor Email _____

Driver's License # _____ Social Security # _____ Res. Phone _____

Employed By _____ How Long? _____ Cell Phone _____

Business Address _____ Bus. Phone _____
STREET CITY ZIP

Spouse's Name _____ Driver's Lic # _____ Soc. Sec. # _____

Employed By _____ How Long? _____ Occupation _____

Business Address _____ Bus. Phone _____
STREET CITY ZIP

Name of nearest relative NOT living with you _____ Relationship _____

Address _____ Res. Phone _____
STREET CITY ZIP

Name of Physician _____ ☐ I HAVE NO PHYSICIAN
ADDRESS PHONE

Former Dentist _____
ADDRESS PHONE

Why are you changing dentists? _____

Purpose of appointment _____

Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person Responsible for this account _____ Relationship _____
PHONE

Address _____
ADDRESS CELL PHONE

PREFERRED METHOD OF PAYMENT ☐ Cash on day of treatment ☐ VISA _____
EXPIRATION

☐ AXP or Discover _____ ☐ MASTERCARD _____
EXPIRATION EXPIRATION

Name of Insurance Company (PRIMARY insurance) _____

Insured Person's Name _____
BIRTHDATE RELATIONSHIP SOCIAL SECURITY #

Name of Group Dental Plan _____
GROUP # PLAN # NAME OF UNION LOCAL

Name of Insurance Company (SECONDARY insurance) _____

Insured Person's Name _____
BIRTHDATE RELATIONSHIP SOCIAL SECURITY #

Name of Group Dental Plan _____
GROUP # PLAN # NAME OF UNION LOCAL

TERMS & CONDITIONS

As a condition of treatment by this office, I understand that financial arrangements must be made in advance. The practice depends on reimbursement from patients for the costs incured in their care and financial responsibility on the part of each patient must be determined before treatment. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. 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 the insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1.5% per month (18% per annum) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of seven months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by Carl J. Dispenziere DDS and/or his staff, I agree to pay, therefore, the reasonable value of said services to Carl J. Dispenziere DDS, or his assignee, at the time said services are rendered, or within 10 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time of payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further 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 shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assignee, to telephone me at home or at work to discuss the matters related to this form.

I have read the above conditions and agree to their content:

SIGNED _____ DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No Name and address : _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Do you or have you taken Fosamax or any Bisphosphanates? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Have you ever had Lap Band or Gastric Bypass surgery ? ◯ Yes ◯ No

Women: Are you Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other

If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had an unfavorable reaction from local anesthetic? ..... ◯ Yes ◯ No

Any serious trouble associated with previous dental treatment ? yes◯ no◯ If so, please explain _____

How long since last full mouth X-Rays? Weeks Months Years How long since last dental treatment? Weeks Months Years

Does dental treatment make you nervous? No Slightly Moderately Extremely Would you like to be pre-sedated? ◯ Yes ◯ No

☐ I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way. ☐ Patient refused/was unable to sign because _____

☐ I have received a copy of the **Dental Materials Fact Sheet** as required by law.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

A Date_____Signature_____Reviewed by_____Lic#_____Date _____

B **UPDATE - Since your last visit "A"**

Have you seen a medical doctor? ◯ Yes ◯ No

Any change in medication? ◯ Yes ◯ No

Change in medical condition or had surgery? ◯ Yes ◯ No

Please note any changes in health since your last visit:

_____

Date_____Signature _____

C **UPDATE - Since your last visit "B"**

Have you seen a medical doctor? ◯ Yes ◯ No

Any change in medication? ◯ Yes ◯ No

Change in medical condition or had surgery? ◯ Yes ◯ No

Please note any changes in health since your last visit:

_____

Date_____Signature _____

REVIEWED BY

A DATE

B DATE

C DATE

A BP___/___Pulse Date_____By **B** BP___/___Pulse Date_____By **C** BP___/___Pulse Date_____By ____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this form, to administer such anesthetics, analgesics, sedatives, and nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the previous page. Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

SIGNED _____ **DATE**_____**Relationship to patient** _____