General Dentistry for Children & Young Adults

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Patient Information

Patient Name: ____ Date:______________
Last First MI

☐ Male ☐ Female Preferred Name: ____

Social Security #: __________________________ Birth Date:__________________________

Phone (Home): _____________ (Work): _____________ Ext:______

(Cellular) _________________ Best time to call: ________________

Address:____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: _______________ Reason for this visit:______________________________

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

☐ AIDS
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems

☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _______________
☐ _______________

• 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
If yes, please explain:____

• Name of Physician: ____ Phone:________________

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:____

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 of legal patient, parent or guardian

Referral Information

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:____

Parent or Responsible Party Information

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ___________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): ______________ (Work): ______________ Ext: _____ (Cellular) ______________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the Parent ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: ______________________________

Address: ____

Street City State Zip Code

☐ DSHS Medical Coupon Only

☐ DSHS Medical Coupon as Secondary Insurance

Insurance Information

Primary

Name of Insured: ____ is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #:______________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ____

Secondary

Name of Insured: ____ is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #:______________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ____

*Appointments **must** be confirmed no later than noon the previous working day.*

We value our guests and only ask that you honor your appointment time and not risk dismissal from the practice.

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.

A service charge of 1½% 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 the 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, at 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 costs and reasonable attorney fees if suit be instituted hereunder.

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 of treatment and payment and agree to their content.

____ Date: _____________ Relationship to Patient: ______________________
Signature of legal patient, parent or guardian

____ Date: _____________ Relationship to Patient: ______________________
Signature of guarantor of payment/responsible party