Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name) Date: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work) _____ Ext.: _____ CELL: _____

PAGER _____ OTHER _____ DRL#: _____ E-Mail: _____

Address: _____ (Street) _____ (Apartment #)

_____ (City) _____ (State) _____ (Zip Code)

Health Information

Your current dental health is: ☐ Good ☐ Fair ☐ Poor
Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Date of last dental visit: _____ Reason for this visit: _____

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

- ☐ Acid Reflux
- ☐ AIDS
- ☐ Allergies _____
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Dental Complications
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hayfever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ M.V.P.
- ☐ Nervous Disorders
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Due Date: _____
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ M.V.P.
- ☐ Nervous Disorders
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Due Date:
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ STD
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfur
- ☐ OTHER
- ☐ _____
- ☐ _____

Are you allergic or have you had a reaction to: ☐ Local Anesthetic ☐ Erythomycin ☐ Aspirin
Are you a smoker or have nicotine use? ☐ Yes ☐ No
Are you taking or have you ever taken Fosamax? ☐ Yes ☐ No
Do you take antacids? ☐ Yes ☐ No If yes, how often? _____
Are you taking any herbal supplements/medicines? ☐ Yes ☐ No If yes, which ones? _____

Do you eat or drink grapefruit? ☐ Yes ☐ No

Food Allergies?_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No Would you like whiter teeth? ☐ Yes ☐ No

- Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain:_____

Name of Medication you are taking:_____

- 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 patient, parent or guardian

Referral Information

Please check the different ways you heard of Dr. May:

☐ Another patient, friend ☐ Another patient, relative

☐ Cable TV ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School

☐ Work ☐ Other _____

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

Responsible Party Information

If patient is a child, information of the parent or guardian

Name: _____

☐ Male ☐ Female ☐ Mother ☐ Father

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell _____

Pager _____ Other _____ DRL# _____

E-Mail _____

Address: _____

Street Apartment #

_____ _____ _____ _____

City State Zip Code

Employment Information

The following is for the patient

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of insurance carrier: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

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

Insurance Plan Name and Address: _____

_____

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Insured's Address if different: _____

Street City State Zip Code

Patient's relationship to insured. ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary

Name of Insurance carrier: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

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

Insurance Plan Name and Address: _____

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Insured's Address if different: _____

Street City State Zip Code

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

Consent for Services

As a condition to your treatment by this office, financial arrangements must be made in advance. The practice collects 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 are solely liable, whether or not 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 process the patient's 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 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days unless previously written financial arrangements are satisfied.

I understand that the fee quotation 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 stated 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 were 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 claim.

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