Patient Information

Patient Name: ____ Date: ______________
Last, First MI (Preferred Name)

Male _______ Female _______ Married _____ Single _____ Child _____ Divorced _____ Widowed _____

Social Security #: __________________________ Birth Date: ___________________________

Phone (Home): _________________ (Work): _________________ Ext: __________ (Cell): _________________

Address: ____
Street Apartment #

____
City State Zip Code

E-Mail Address: ________________________________

Pharmacy name, town and phone number: ____

Name of most recent dentist:____ Date of last dental visit: ______________

Emergency Contact Information: Name: _______________________Phone:_________________

Please circle those that apply:

- Anemia
- Angina pectoris
- Arthritis
- Aspirin allergy
- Asthma
- Bisphosphonate treatment
- Blood disease/disorder
- Bronchitis
- Cancer
- Codeine allergy
- Congenital heart disease
- Congestive heart failure
- Diabetes
- Drug/alcohol dependency
- Epilepsy
- Glaucoma
- Heart disease and/or attack
- Heart murmur
- Heart surgery
- Hepatitis (Circle type A B C)
- High blood pressure
- HIV Positive/AIDS
- Joint replacement
- Kidney disease
- Lung disease
- Latex allergy
- Liver disease
- Low Blood Pressure
- Mental and/or nervous disorder
- Organ and/or medical transplant
- Osteoporosis
- Pacemaker
- Penicillin allergy
- Pregnancy
- Due Date: ____________
- Psychiatric treatment
- Radiation/chemotherapy
- Renal failure
- Rheumatic fever
- Smoker
- Stroke
- Thyroid disease
- Tuberculosis
- Venereal disease
- Any past surgeries?

____

Have you ever been advised against taking any specific type of medication?

____

Any other allergic conditions not listed?

____

Have you ever had Periodontal Gum Disease/ Gingivitis ?

____

Please list any and all MEDICATIONS/SUPPLEMENTS & VITAMINS you are currently taking. Please use this space to clarify any medical history or conditions that are not fully explained in the above spaces: ____________

____

____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of physician: ____ Phone number: __________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

Referral Information

Who can we thank for referring you to our practice? ____

What got you to pick up the phone and make this appointment?

____

____

How do you feel about being here?

____

Parent or Responsible Party Information

If patient is responsible party, please skip this section and go to the next section (Employment Information)

Name____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _______________

Social Security #: ________________________________ Birth Date: ______________________________

Phone (Home): ________________ (Work): ________________ Ext: _________ Best time to call: _________

Address: ____
Street Apartment #

____
City State Zip Code

Insurance Information

Primary Subscriber

Name of insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's birth date: ___________________ Insured's SSN: ___________________

Insurance ID #: ________________________________ Insurance 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 claim mailing address: ____

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the said Dentist or Dental entity.

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 three months from the date of the patient examination.

I have received Notice of Privacy Practices for Newman Springs Dental Care.

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. 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.

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. I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I give my consent for the administration of any medication that may be required as a life-saving measure. I authorize the staff of Newman Springs Dental Care to use photographs, x-rays and treatment records for the purpose of teaching, marketing, research and scientific publications.

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 agree to their content.

Signature of patient, parent or guardian:

____ Date: ____________ Relationship to patient: _____________________

Reviewed by treating dentist: __________________________________ Date: ___________

ASA Classification: ________________