Patient Information

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

Gender: _____ Family Status:_____

Social Security #_____ Birth Date: _____

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

Email Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Reason for this visit:_____

Do you now, or have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer/Chemo
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear Pain/Congestion
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injuries
- ☐ Heart Concerns
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ History of HPV
- ☐ Jaw Pain or Noise
- ☐ Limited Opening
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Premedication Needed
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Smoking / Years___
- ☐ Chewing tobacco / Years ___
- ☐ Snoring
- ☐ Substance Abuse
- ☐ Tooth Clenching/Grinding
- ☐ Women; Are you Currently pregnant?
  - ☐ Due date:_____
- OTHER:
- ☐ _____

- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Are you allergic to any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have a general physician? ☐ Yes ☐ No
  Name of Physician: _____ Phone: _____

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

Spouse or 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: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

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

Employer Name:_____Occupation: _____

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 patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Please read & INITIAL each item below. Your understanding of these items allows us to make your dental care our priority and the business end of things easy for both of us. This document covers you and your dependent children.

_____ **Appointment Guidelines:** I agree to respect the appointment times reserved for me. I understand that this dental team asks for ***at least*** 48 business hours if I need to move or cancel an appointment since late cancellation or failure to show for an appointment causes 'schedule distress' to the dental office. I also understand that I *may* be charged a late cancelation fee, based on the reason, for a missed or failed appointment and that the dental team has the right to refuse to reschedule me if I late cancel too often or miss too many appointments.

_____ **Care to Minor Children:** I understand that the adult who brings a minor child to a dental appointment assumes the financial responsibility for care to that minor. I understand that this office will not get involved in custody, divorced/separation arrangements, etc. Per Nebraska law, a minor is a young person under the age of 19.

_____ **Minor Children in the office:** By law patients ***under*** the age of 19 are considered minors. We require a parent or guardian be with minor children at their dental appointments unless arrangements are made with the Business Manager prior to the appointment. A parent/guardian may be allowed in the exam room if the parent/guardian feels it will be beneficial to the minor child. However, sometimes children behave better without a parent/guardian present.

_____ **Photos/Videos:** I authorize members of this dental team to take photos and/or video of my face, jaws and teeth before, during and after treatment, and that my name or other identifying information will be kept confidential. I understand I will not be compensated for any photo or video taken or used.