



## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative

Dental Office  Yellow Pages  Newspaper  Radio  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

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

- |                                            |                                              |                                               |                                             |
|--------------------------------------------|----------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| _____                                      | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> <b>Pregnancy</b>     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries       | Due date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       |                                             |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |                                             |

• 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 patient, parent or guardian

## Consent for Services

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that before treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

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 90 days from the date of the patient examination.

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