Patient Information

Date

Patient's Name ______ (LAST / FIRST / MIDDLE INITIAL) Age ______ Birthday ______ ○ Male ○ Female

If patient is a minor, give name of parent or legal guardian ______ Relationship ______

Address ______ (STREET / CITY / ZIP) For how long? ______ ○ Own ○ Rent

Patient is: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Minor Email ______

Driver's License No. ______ Social Security No. ______ Home Phone ( ) ______

Mobile Phone ( ) ______

Employed by ______ How long? ______

Occupation ______

Business Address ______ (STREET / CITY / ZIP) Work Phone ( ) ______

Spouse's Name ______ (LAST / FIRST / MIDDLE INITIAL) Home Phone ( ) ______

Driver's License No. ______ Social Security No. ______ Mobile Phone ( ) ______

Employed by ______ How long? ______ Occupation ______

Business Address ______ (STREET / CITY / ZIP) Work Phone ( ) ______

Name of nearest relative not living with you ______ Relationship ______

Address ______ (STREET / CITY / ZIP) Home Phone ( ) ______

Physician Info ______ (NAME / ADDRESS / CITY / PHONE)

Former Dentist ______ (NAME / ADDRESS / CITY / PHONE)

Why are you changing dentists? ______

Do you wish to speak to the doctor privately? ○ Yes ○ No

Purpose of appointment ______

Is this visit for emergency dental care? ○ Yes ○ No If yes, please explain ______

School Children Attend ______ Whom may we thank for referring you? ______

Financial Information

Person responsible for this account ______ Relationship ______

Address ______ (STREET / CITY / ZIP / TELEPHONE / MOBILE)

Preference of Payment ○ Cash on day of treatment ○ State Aid # ______ ○ Other ______

○ Visa ______ (CARD NUMBER / EXPIRATION DATE) ○ Mastercard ______ (CARD NUMBER / EXPIRATION DATE)

Name of Insurance (Primary) ______

INSURED PERSON'S NAME / BIRTHDATE / RELATIONSHIP / SOCIAL SECURITY NO.

GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL

Name of Insurance (Secondary) ______

INSURED PERSON'S NAME / BIRTHDATE / RELATIONSHIP / SOCIAL SECURITY NO.

GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL

ARCADIA
DENTAL CLINIC

Terms & Conditions

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursment from the patients for the costs incured in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid in cash at the time services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insruance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. **Assignment of Insurance:** I hereby authorize my insurance company to pay directly to my dentist benefits acruing to me under my policy. A service charge of 1½ % per month (18% per annum) (but in no event more than the maximum rate permissible under state law) wil be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, 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 ______ Date ______

Medical History

★ The questions are for your benefit and assure that treatment will take into consideration your overall (past and present) health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

1. Are you in good health? .... Yes No
2. Date of last physical examination ________
3. Are you now under the care of a physician? .... Yes No
   If yes, what is the condition being treated? ________
4. Have you ever had any serious illness or operation? .... Yes No
   If yes, what illness or operation? ________
5. Have you ever been hospitalized? .... Yes No
   If yes, why were you hospitalized? ________
6. Are you taking any ◯ medications ◯ drugs or ◯ herbs?
   If yes, what? ________ What dosage? ________
7. Are you using or have been exposed to any recreational drugs (marijuana, cocaine, etc.)? ◯ Yes ◯ No. If Yes, What? ________
8. Have you ever been premedicated with antibiotics for your dental treatment? .... Yes No
9. Are you sensitive or allergic to any drugs or materials? ◯ Penicillin; ◯ Tetracycline; ◯ Sulfa Drugs; ◯ Asperin; ◯ Codeine; ◯ Latex; ◯ Others ..... Yes No
   If Others, what drugs? ________
10. Do you have or have you had any of the following? (Please carefully read all conditions)

☐ Anemia	☐ Implant (s)	☐ Head Injuries	☐ Drug Addiction	☐ Blood Transfusion	☐ Excessive Bleeding	☐ Osteoporosis
☐ Herpes	☐ Headaches	☐ Heart Failure	☐ Kidney Disease	☐ Joint Replacement	☐ Mitral Valve Prolapse	☐ X-Ray or Cobalt Treatment
☐ Stroke	☐ Glaucoma	☐ Scarlet Fever	☐ Chemotherapy	☐ Nervous Disorders	☐ High Blood Pressure	☐ Radiation Treatment of any kind
☐ Ulcers	☐ Tonsillitis	☐ Sinus Trouble	☐ Stomach Ulcers	☐ Tumors or Growths	☐ HIV Related Complex	☐ Venereal Disease (Syphilis, Gonorrhea)
☐ Diabetes	☐ Hemophilia	☐ Heart Murmur	☐ Angina Pectoris	☐ Allergies or Hives	☐ Respiratory Disease	☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ Arthritis	☐ Cold Sores	☐ Liver Disease	☐ Mental Disorder	☐ Pain in Jaw Joints	☐ Epilepsy or Seizures	☐ TMJ (Temporomandibular Joint) Disorder
☐ Asthma	☐ Emphysema	☐ Blood Disease	☐ Thyroid Disease	☐ Artificial Prosthesis	☐ Psychiatric Treatment	☐ Other ________
☐ Cancer	☐ Heart Ailments	☐ Heart Ailments	☐ Fainting Spells	☐ Sickle Cell Disease	☐ Hepatitis or Jaundice	
☐ Seizures	☐ Rheumatism	☐ Heart Attack	☐ Rheumatic Fever	☐ Cortisone Medicine	☐ Difficulty Swallowing	
☐ Hay Fever	☐ Bruise Easily	☐ Cerebral Palsy	☐ Tuberculosis (T.B.)	☐ Allergies to Metals	☐ Congenital Heart Lesions	

11. Do you have any disease, condition or problem not listed that you think we should know about? .... Yes No
    If yes, what? ________
12. Do you wear a cardiac pacemaker or have you had heart surgery? .... Yes No
13. Do you smoke? If yes, how much? ________ ◯ cigarettes ◯ cigars ◯ packs per day .... Yes No
14. Have you ever taken any of the following drugs? ◯ Fen-Phen ◯ Redux or any ◯ diet drugs? .... Yes No
15. Are you pregnant? If so, how many months? ________ Yes No
16. Do you have any problems associated with your menstrual period? .... Yes No
17. Do you take any birth control medication or hormones? .... Yes No

Dental History

1. Have you ever had a local anesthetic (Novocaine, etc.)? .... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? .... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
   If so, explain ________
4. How long since your last full mouth X-Rays? ____ Weeks ____ Months ____ Years
5. How long since your last dental treatment? ____ Weeks ____ Months ____ Years
6. Does dental treatment make you nervous? ◯ Slightly ◯ Moderately ◯ Extremely .... Yes No
7. Would you prefer to be pre-sedated? .... Yes No

a Date ________ Signature ________ Reviewed by ________ Lic. # ________ Date ________

b Update – Please note changes in health since last visit (a). Write "None" If there are no changes.

1. Have you seen a medical doctor? .... Yes No
2. Have you had a change in your medication? .... Yes No
3. Have you had a change in your medical condition or had surgery? .... Yes No

____

Date ________ Signature ________

c Update – Please note changes in health since last visit (b). Write "None" If there are no changes.

1. Have you seen a medical doctor? .... Yes No
2. Have you had a change in your medication? .... Yes No
3. Have you had a change in your medical condition or had surgery? .... Yes No

____

Date ________ Signature ________

DO NOT WRITE ON THIS SPACE. FOR REVIEWER ONLY.

a - Reviewed by ________ Date ________

b - Reviewed by ________ Date ________

c - Reviewed by ________ Date ________

	a	b	c
Date			
B.P.	/	/	/
PULSE			
TEMP			
BY			

☐ I hereby acknowledge I have received a copy of this practice's **Notice of Privacy Practices**. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified or changed in any way. ☐ Patient refused / was unable to sign because ________

☐ I have received a copy of the **Dental Materials Fact Sheet** as required by law. To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Consent for Treatment: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs. **All services are rendered and accepted under the terms and conditions printed on the reverse hereof:**
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed ________ Date ________ Relationship to Patient ________