

Patient Information

Patient Name: _____ Preferred Name: _____
Last First M
 Male Female Married Single Child Other: _____
Social Security #: _____ Email: _____ D.O.B: _____
Phone (Home): _____ (Work): _____ (Cell): _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of last Dental visit: _____ Reason for today's visit: _____

Describe the nature of any health conditions you are currently being treated for:

<u>Conditions</u>	<u>Date of Onset</u>	<u>Physician/ Physician's Phone #</u>	<u>Medicines being taken</u>

List all other medications you are currently taking:

Describe any other conditions you have been treated for in the past five years.

<u>Condition</u>	<u>Date Treated</u>	<u>Physician</u>	<u>Physician's Phone #</u>

- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

Have you ever had any of the following? Please check those that apply, if not already noted above:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> COPD or Emphysema |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Sinus Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems or Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Benign Tumors | <input type="checkbox"/> Heart Attack Date: _____ | <input type="checkbox"/> Mental or Nervous Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Prosthetic Heart Valve |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Other Medication cannot take |
| <input type="checkbox"/> Epilepsy | | | |

- Have you ever had any complications following dental treatment or dental injections? Yes No
If yes, please explain. _____

- Are you interested in Sedation? Yes No

- Is there anything you want to change about your smile? _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform my doctor at the next appointment without fail.

Signature of Patient, Parent, or Guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice?

Internet Yellow Pages Newspaper Flyer Work Other: _____

Another patient, friend Another patient, relative

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

Spouse or Responsible Party Information

The following is for: The patient's spouse The person responsible for patient

Name: _____

Male Female Married Single Child Other: _____

Social Security #: _____ Birth Date: _____

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

Address: _____

Street Apartment #

City State Zip Code

In case of Emergency, call: _____ **Phone (Work):** _____ **(Cell)** _____

(Close Relative not living at your home address)

Employment Information

The following is for: The Patient The person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last First Middle

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

Insured's Employer Name: _____

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

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last First Middle

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

Insured's Employer Name: _____

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

Insurance Plan Name and Address: _____

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. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of 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 if 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.

I grant permission to Joel F. Bookout D.D.S., P.C. for use of my photographs for educational and commercial purposes.

A service charge of 1.5% per month (18% per annum) or \$5.00, which ever is greater, will be charged on the unpaid balance of all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 (5) days billing if credit shall be extended. I further agree that a waiver if 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 collections and reasonable attorney fees if suit be instituted hereunder.

I grant 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.

Signature of Patient, Parent, or Guardian Date: _____ Relationship to Patient: _____

Signature of Guarantor of payment/ responsible party Date: _____ Relationship to Patient: _____