Central Dental Associates

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Today's Date: _____

Patient Information

Patient Name: _____ Preferred Name_____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Date of Birth:_____/_____/_____

Home Address:_____ City _____ State _____ ZIP_____

E-mail address: _____

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

Best time to call:_____

Contact in Case of Emergency: _____Home Phone: _____Work:_____

How did you hear about our office: _____

Primary Dental Insurance /Account Information

Subscriber's Last Name: _____First Name_____

Social Security #: _____ Date of Birth:_____/_____/_____

Home Address:_____ City _____ State _____ ZIP_____

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

Insured's Relationship to Patient _____ Employer sponsoring Insurance Plan _____

Insurance Company _____ I.D. #_____

Mailing Address _____

City _____ State _____ ZIP_____

Secondary Dental Insurance /Account Information

Subscriber's Last Name: _____First Name_____

Social Security #: _____ Date of Birth:_____/_____/_____

Home Address:_____ City _____ State _____ ZIP_____

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

Insured's Relationship to Patient _____ Employer sponsoring Insurance Plan _____

Insurance Company _____ I.D.# _____

Mailing Address _____

City _____ State _____ ZIP_____

Please turn to next page

Patient Medical History

Name of Physician: _____ **Telephone:** _____ **Date of Last Exam:** _____

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

Allergies _____
_____
_____
_____

☐ Anemia
☐ Arthritis
☐ Artificial Joints/ Date of surgery: _____
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths/Tumors
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A / B / C
☐ High Blood Pressure
☐ HIV/ Aids
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy** Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sexually transmitted disease
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Other: _____
_____

- Are you taking any **MEDICATIONS**? (Including pain relievers, antibiotics, birth control etc) ☐ Yes ☐ No
  If yes, please explain: _____
  _____
  _____

- Do you require any **PRE-MEDICATION** prior to dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____

Patient Dental History

Previous Dentist: _____ **Telephone:** _____ **Date of Last Exam:** _____
What is the purpose of today's visit? _____
Do you have/have you had any of the following?

1) Teeth sensitive to heat? Y / N
2) Teeth sensitive to cold? Y / N
3) Teeth sensitive to sweets? Y / N
4) Teeth sensitive when biting? Y / N
5) Pain in any of your teeth? Y / N
6) Swelling in your face or mouth? Y / N
7) Complications following dental treatment? Y / N
8) Bleeding Gums? Y / N
9) Loose teeth? Y / N
10) Do you like your smile? Y / N
11) Have you been considering bleaching your teeth? Y / N

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. I authorize the use of my signature on all insurance submissions. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. 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