Patient Information

Patient Name: ______________________________ Date:__________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: ____________________ Birth Date:____________________

Phone (Home): __________ (Work): __________ Ext:____ Email/Pager __________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: __________ Reason for today's visit:____________________

Have you ever had any of the following? Please circle "Y" (YES) or "N" (NO). All questions must be answered:

Y N AIDS/HIV
Y N Allergies/Hay Fever: __________
Y N Anemia
Y N Arthritis/Rheumatism
Y N Artificial Joints/ Joint Replacement
Y N Asthma/Bronchitis/ Respiratory Problems
Y N Blood Disease
Y N Cancer
Y N Diabetes
Y N Dizziness
Y N Epilepsy
Y N Excessive Bleeding
Y N Fainting
Y N Glaucoma
Y N Growths/Tumors
Y N Head Injuries
Y N Heart Disease

Y N Heart Murmur
Y N Heart Valve Problems
Y N Hepatitis
Y N High Blood Pressure
Y N Jaundice
Y N Kidney Disease
Y N Liver Disease
Y N Mental Disorders
Y N Multiple Sclerosis
Y N Nervous Disorders
Y N Pacemaker
Y N **Pregnancy (now)**
Due date:__________
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Sinus Problems
Y N Stomach Problems
Y N Stroke
Y N Tuberculosis

Y N Ulcers
Y N Venereal Disease
Y N Codeine Allergy
Y N Penicillin Allergy
Y N Other Drug Allergy:
____
____
____
Y N Antibiotic Premed-Ication for Dental Work
Y N Mitral Valve Prolapse
Y N Tobacco Use
Y N Alcohol Use
Y N Latex Allergy
Y N Low Blood Pressure
Other Medical Problems:
____
____

____
List All Medications/Herbs/ Vitamins You Take:
____
____
____
____
____
____
____

- 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:______________________________

Employment Information

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

Employer Name: ____________________ Occupation: ____________________

Address: ______________________________
Street City State Zip Code

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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

◆◆Insurance Information◆◆

➔*Please let us have your insurance cards!*➔

We must have the following information in order to send your insurance claim: Subscriber Name, DOB, SSN, insurance ID Number; Name of Insurance Company, Mailing Address, Toll Free Telephone Number, Group Number or Policy Number. Please give us your insurance card to copy or the insurance form supplied by your employer.

Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other____________

◆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/my dependents health, I will inform the doctor and staff at the next appointment without fail.

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. **I give permission for Dr. Boone's office to take necessary x-rays of my minor child/dependent.**

______________________________ Date: __________ Relationship to Patient: ______________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party

Revised March 2005