

Patient Information

Patient Name: _____ Date _____
Last First MI
 Male Female Married Single Child
Social Security #: _____ Birth Date: _____
Home#: _____ (Work): _____ Best time to call _____
Cell#: _____ E-Mail Address _____
Address _____
Street Apt.# City Zip Code

Spouse or Responsible Party Information

The following is for : the patient's spouse the person responsible for payment
Name: _____
Last First MI
 Male Female Married Single
Social Security #: _____ Birth Date _____
Home#: _____ Work#: _____
Address: _____
Street Apt.# City Zip Code

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to Signature Dental?
 Passing by Yellow Pages Another patient Friend
 Work Insurance Plan Guide Relative Other _____
Name of person referring you to us: _____

Please continue on back.....

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"/> Epilepsy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis or Rheumatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Artificial Heart Valve/Joint | <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis or Liver Disease | List allergies to: (medication, latex, etc) |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Radiation Therapy | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory Problems | Female Patients: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Pregnant |
| | | <input type="checkbox"/> Taking birth control pills |

Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

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

Name of Physician: _____ Phone: _____

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

List medications you are currently taking: _____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I am responsible to inform this office of any change in health information.

_____ Date _____

Signature of patient, parent, or guardian

Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time of service rendered. Patients who carry dental insurance understand that all dental services performed are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Signature Dental will help prepare the patient's insurance or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, we cannot render services on the assumption that our charges will be paid by an insurance company. 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 her assignee, at the time said services are rendered. I further agree that a waiver of any time or condition there under 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 for Signature Dental and its assignee, to telephone me at home or work to discuss matters related to my dental care.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to patient: _____

Signature of patient or responsible party