



MEDICAL HEALTH

General Health: Excellent Good Fair Poor Date of Last Physical: _____
Name & Address of Physician: _____
Please list all medications you are presently taking: _____

Have you been hospitalized or under a doctor's care during the past 3 years? Yes No
Has a doctor told you that you need antibiotics to pre-medicate for dental work? Yes No

Please check all of the following that you have had or have now:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Disease or Surgery | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Asthma/Cough |
| <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach Problems/Ulcers | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Contact Lenses |

Do you have any disease, condition or problem not listed? _____

Are you allergic to: Penicillin Codeine Local Anesthetic (injected) Other _____

Are you subject to prolonged bleeding? Yes No

Women: Are you pregnant? Yes No Are you taking birth control medication? Yes No

FINANCE

Payment of portions not covered by insurance is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option that you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

- Cash Personal Check Visa Master Card Discover

Card #: _____ Exp. Date: _____

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party payers and/or health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I understand that payment is due at the time of service. I understand that if my account reaches collection status (90 days), my account may be turned over to a collection agency. I will pay ALL costs of collection, including court costs and attorney's fees incurred for collection. Additionally, if my account reaches collection status (90 days), I agree to pay a monthly late fee in an amount equal to 1.5% of my remaining balance.

Signature of patient (or parent if minor) _____ Date _____

I, _____ verify all information provided on these forms is completely accurate to the best of my knowledge.

Signature of patient (or parent if minor) _____ Date _____