CHESTERFIELD DENTAL ASSOCIATES

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other (Divorced/Separated/Widowed)

Social Security #: _____ Birth Date: _____

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

E-mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Please choose your preference for Confirmation/Recall Notices: ☐ Email or ☐ Text

Health Information

- Approximate year of your last dental visit? _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain: _____

_____

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

☐ AIDS/HIV+
☐ Allergies (Hay fever/Seasonal)
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Behavioral Disorders
☐ Blood Disease
☐ Blood Thinner Medication
☐ Cancer Year:_____
☐ Chemotherapy
☐ Dementia
☐ Diabetic Type 1 or 2
☐ Dialysis
☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders (anxiety/depression)
☐ Migraines
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Osteoporosis/take(n) bisphosphonates
☐ Pacemaker
☐ Pregnancy (current) Due Date _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers _____

- Do you have any medical conditions for which you are being treated or taking medication? ☐ Yes ☐ No
  If yes, please explain: _____
- Please list any current medications (we will copy your list of meds to attach): _____

_____

- Have you been advised of any medical conditions require **pre-medication** (antibiotic) before dental treatment? If yes, what condition? ☐ Yes ☐ No _____
- Have you been admitted to the hospital since your last visit with us? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you **allergic** to any medication(s)? ☐ Yes ☐ No
  ☐ Codeine Allergy ☐ Epinephrine Allergy ☐ Latex Allergy ☐ Penicillin Allergy ☐ Sulfa Allergy
  If yes, please list the medication(s) _____
- Are you currently smoking? ☐ Yes ☐ No
  If yes, how much? _____ For how long? _____
- Name of Physician: _____

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 health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Who may we thank for referring you to our practice: ☐ Another patient/friend ☐ Another patient/relative
☐ Insurance Plan ☐ Internet ☐ Other ☐ School ☐ Work ☐ Yellow Pages/YP.com

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

Spouse or Responsible Party Information

Relationship to patient: ☐ self ☐ the patient's parent ☐ the patient's spouse ☐ Other person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary Insurance Carrier

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Secondary Insurance Carrier

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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 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.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

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