Patient's Information

EMPLOYMENT INFORMATION

Place of Employment:_____ Position or Occupation:_____
Address:Street_____ City:_____ State:_____
How long there:_____ Do you have Dental Insurance through work? ☐ Yes ☐ No How long covered?_____

Spouse Information or Responsible Party Information

Adults are responsible for their own account, unless child over 18 still covered by parents insurance. We will file spouse's insurance if covered.
The following is for: ☐ Spouse ☐ Person responsible for account. ☐ Male ☐ Female
Name:Last_____ First_____ MI_____
Address:(If different from own)Street_____ City_____ State_____ Zip_____
Phone:_____ Work Phone:_____ Ext:_____ Cell Phone:_____
Date of Birth:_____ Social Security#_____ Are they Currently A Patient Here? ☐Yes ☐No
Place of Employment:_____ Position or Occupation:_____
How long there:_____ Do they have Dental Insurance through work? ☐Yes ☐No How long covered?_____

Primary Insurance

Dental Insurance Information

Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other_____ Is insured a Patient here? ☐Yes ☐No
Name of Policyholder:Last_____ First_____ MI_____ How long insured?_____
Policyholder's Birth Date:_____ SocialSecurity#_____ Group#_____ ID#_____
Policyholder' Employer:_____ Address:_____
Insurance Plan Name:_____ Address:Street or P.O._____
City:_____ State:_____ Zip Code:_____ Phone #_____

Secondary Insurance

Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other_____ Is insured a Patient here? ☐Yes ☐No
Name of Policyholder:Last_____ First_____ MI_____ How long insured?_____
Policyholder's Birth Date:_____ SocialSecurity#_____ Group#_____ ID#_____
Policyholder' Employer:_____ Address:_____
Insurance Plan Name:_____ Address:Street or P.O._____
City:_____ State:_____ Zip Code:_____ Phone #_____

Referral Information

How did you hear about our office? ☐ Patient (friend) ☐ Patient (relative) ☐ Dental Office ☐ Word of mouth ☐ Work
☐ Yellow Pages ☐ Newspaper ☐ School ☐Other_____
Name of person we may thank for referring you:_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patients for the costs incurred for their care, and financial responsibility on the part of each patient must be made before treatment.
•••All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at time services are performed.

Patients who carry dental insurance must understand that all dental insurance is a contract between the insurance company and the insured, not us. We do not take any responsibility for services implied covered by insurance companies. Services furnished are charged directly to the patient and he or she is personally responsible for payment in the event dental services are not covered or a balance is remaining.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the fee for services to said Doctor, or his assignees, at the time said services are rendered, or within ten (10) days of billing if credit should be extended. I understand a finance charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. If no payment for patients with financial arrangements have been made a late charge will be added per month.

I further agree that the reasonable value of said services shall be billed unless contacted by me, in writing, within the time for payment thereof. I further agree that a waiver of any breech at 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 suet be instituted hereunder. I furthermore agree that if outside services are enrolled in order to collect said balances, I agree to pay collection fees in addition to original balance and finance charges will continue to accrue after being turned over to collection/Credit reporting companies.

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

Signature of Patient:_____ Date:_____
Signature of Guarantor:_____ Date:_____ Relationship:_____

TODAY'S DATE _____ PATIENT INFORMATION

Patient Name: Last _____ First _____ MI _____ Preferred Name: _____

Address: Street _____ Apartment # _____ ☐ Own ☐ Rent

City _____ State _____ Zip Code _____

Date of Birth: ____/____/____ Social Security # ____-____-____ ☐ Male ☐ Female ☐ Single ☐ Married

Home Phone: _____ Cell Phone: _____ E-Mail Address _____

Work Phone: _____ Ext: _____ Fax: _____ Other contact number? _____

Do you have a preference of Doctors? Dr.Gangwisch?_____ Dr.Grandy?_____ Dr. Melzer?_____

HEALTH INFORMATION

Date of Last Dental Visit: _____ Request records?____ From Whom? _____

Reason for today's visit: _____

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

☐ AIDS/HIV	☐ Excessive Bleeding	☐ MITRAL VALVE PROLAPSE	☐ Tuberculosis
☐ Allergies	☐ Fainting	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Glaucoma	☐ No Epinephrine	☐ ULCERS
☐ Arthritis	☐ Growths	☐ Nursing Presently	☐ Venereal Disease
☐ Artificial Joints	☐ Hay Fever	☐ Pacemaker	☐ Osteoporosis Medications?
☐ Aspirin Therapy	☐ Head Injuries	☐ Pregnant At Present?	☐ Fosamax?
☐ Asthma	☐ Heart Disease	☐ Due Date:_____	☐ Boniva?
☐ Blood Disease	☐ Heart Murmur	☐ Radiation Treatment	☐
☐ Cancer	☐ Hepatitis A B C	☐ Respiratory Problems	☐
☐ Chemotherapy	☐ High Blood Pressure	☐ Rheumatic Fever	☐ DRUG ALLERGIES
☐ Coumadin	☐ Jaundice	☐ Rheumatism	☐ Codiene Allergy
☐ Diabetes	☐ Kidney Disease	☐ Sinus Problems	☐ Erythromycin Allergy
☐ Dizziness	☐ Leukemia	☐ Stomach Problems	☐ Penicillin Allergy
☐ Drug or Alcohol Abuse	☐ Liver Disease	☐ Stroke	☐ Other Allergies, Please List:
☐ Epilepsy	☐ Mental Disorders	☐ Sulfa Allergy	☐

- Name of Physician/Physicians: _____ Phone# _____
- Are you presently under Doctor's care or being treated for any conditions? ☐ Yes ☐ No If yes, please explain: _____
- Taking Medications Now (Include over the counter)? ☐ Yes ☐ No If yes, please List: _____, _____, _____, _____, _____, _____, _____
- Have you been admitted to the hospital, needed emergency care, or had surgery during the past two years? ☐ Yes ☐ No If yes, please explain: _____
- Have you ever had any complications during or after dental treatment? ☐ Yes ☐ No If yes, please explain: _____
- Contact in an emergency: Name _____ Phone _____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT. IF EVER I HAVE ANY CHANGE IN MY HEALTH, I WILL INFORM THE DOCTORS AT THE NEXT APOINTMENT.

Signature of Patient: _____ Date: _____