CITY CENTER Dental Care

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## Patient Information

**Patient Name:** _____ **Date:** _____
Last First M I (Preferred Name)

**Gender:** ☐ Male ☐ Female **Family Status**: ☐ Single ☐ Married ☐ Other

**Social Security #:**_____ **Birth Date:** _____ **E-mail:** _____

**Phone:** Home _____ Work _____ Mobile _____

**Please check the payment method you prefer**: ☐ Cash ☐ Personal Check ☐ Credit Card

**Address:** _____
Street Apartment #

_____
City State Zip Code

**Emergency Contact:** _____ **Phone:** _____
Name Relationship

## Health Information

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

**Please check all conditions that you have now or have had in the past:**

☐ Abnormal Bleeding
☐ AIDS or HIV+
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Cancer - Chemotherapy/Radiation
☐ Diabetes - Type I or II
☐ Eating disorder
☐ Epilepsy/Seizures
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hepatitis/Jaundice
☐ Codeine Allergy
☐ Osteoporosis
☐ Kidney Disease

**Cardiovascular Disease**
**Please specify:**
☐ Angina
☐ Arteriosclerosis
☐ Artificial heart valves
☐ Congenital heart defects
☐ Congestive heart failure
☐ Coronary artery disease
☐ Heart Attack
☐ Heart Murmur
☐ Headaches, frequent
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Fever

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ ***Pregnant Now***
Due date:_____
☐ Respiratory Problems
☐ Sinus Problems
☐ GERD/Heartburn
☐ Stroke
☐ Thyroid condition
☐ Tobacco Use
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Sexually Transmitted Disease
☐ Penicillin Allergy
☐ Latex Allergy

☐ Other Allergies:
_____
☐ Are you taking, or have you taken:
☐ Pondimin, Redux, or Phen-fen?
☐ Fosamax, Boniva, Actonel or other bisphosphonates?
☐ Do you use drugs or other substances for recreational purposes?
If yes, please identify:
_____
☐ A physician or dentist has recommended that I take antibiotics before dental treatment.

- Please list any medications (prescription, over the counter and herbal supplements) that you are currently taking.
  _____
- Have you ever had any complications following dental treatment? ☐ 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: _____
- Has anyone reported that you choke or gasp for air while you are sleeping? ☐ Yes ☐ No
- Do you snore? Yes No Do you now or have you ever used CPAP? Yes No
- Would you like to discuss your options for teeth whitening? ☐ Yes ☐ No
- Are you open to the Doctor praying with you or for you regarding your dental care? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I, or a patient I am responsible for, ever have any health changes, I will inform the staff at the next appointment without fail.

_____ **Date:** _____
**Signature of Patient or Responsible Party**

## 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 _____ Mobile _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

## Dental Benefits Information

**Primary**

Name of Subscriber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

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

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Dental Benefit Plan Name and Address: _____

_____

**Secondary**

Due to the unpredictable coverage of secondary dental benefits, we do not file or estimate these benefits.
We will assist you with the necessary paperwork to file secondary benefits.

## Consent for Services and Payment Policy

P**LEASE READ AND INITIAL:**

_____I am aware that fees for dental services, which include unpaid balances, deductibles and co-payments, are due at the time of service unless other arrangements are made in advance.

_____If I have dental benefits, I am aware that as a courtesy to me**,** this office will prepare forms and submit necessary documents to my benefit company. However, I realize that my benefit policy is a contract between me, my employer and the benefit company, and that I, not my benefit company, am ultimately financially responsible for all charges for treatment rendered. If my dental benefit company does not pay within 60 days, I agree to accept responsibility for any unpaid balance.

_____I realize that accounts which are not paid within 30 days after being billed are subject to a 1% per month (12% per annum) finance charge on the unpaid balance. Overdue or unpaid accounts may be turned over to a collection agency, and I will be responsible for all of the costs of collection, including court costs, collection agency fees and attorney fees.

**I understand the above policies and accept responsibility for ☐ myself or ☐ patient:** _____
**Printed Name**

_____ **Date**: _____ **Relationship to Patient:** _____
**Signature of Patient or Responsible Party**

## Referral Information

**Whom may we thank for referring you to our practice?** ___ Another Patient ___ Another Doctor
___ Dental Office Staff ___ Internet ___ Advertisement ___ Other: _____

Name of person referring you to our practice_____