

MEDICAL HISTORY AND CONSENT FORM DENTAL EXCELLENCE

PATIENTS INFORMATION

Patient's Name		Marital Status S M W D SEP					Date Of Birth	Age	Sex	Social Security #
Street Address <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		City And State				Zip Code		Home Phone #		
Cell Phone #		Pager #				E-mail				
Patient's Employer		Occupation (Indicate If Student)				How Long Employed		Business Phone #		
Employer's Street Address		City And State				Zip Code				
Spouse's Name		Spouse's Employer				Occupation		How Long Employed	Bus Phone #	
Spouse's Employer's Street Address		City And State				Zip Code				
Referred By:		Street Address				City, State, Zip Code				
Name of Nearest Relative Not Living At Home		Phone		Street Address			City, State, Zip Code			

IF THE PATIENT IS A MINOR OR STUDENT

Father's Name		Street Address, City, State, Zip Code				Home Phone #	
Father's Employer		Occupation			How Long Employed	Business Phone #	
Employer's Street Address		City And State				Zip Code	
Mother's Name		Street Address, City, State, Zip Code				Home Phone #	
Mother's Employer		Occupation			How Long Employed	Business Phone #	
Employer's Street Address		City And State				Zip Code	
Person Responsible For Payment, If Not Above		Street Address, City, State, Zip Code				Home Phone #	

INSURANCE INFORMATION

Primary Insurance Co:		Subscriber Name:			Birth Date:	
Policy I.D. Number:			Group #:			
Secondary Insurance Co:		Subscriber Name:			Birth Date:	
Policy I.D. Number:		Group #:				

PATIENTS WITH DENTAL INSURANCE

Patients with dental insurance are requested to provide completed, signed insurance forms or group and certificate number for each member of the family receiving treatment. We request that your percentage of the charges be paid at each appointment. After the insurance carrier pays, any credit balance will be promptly refunded. Patients with insurance which pays directly to the patient are requested to make full payment as services are rendered. **Dental insurance is a contract between you and your insurance company. We are happy to assist you by processing insurance forms and providing necessary information, but just as in the case of non insurance patients, you are ultimately responsible for your account. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.**

Signature _____ Date _____

MEDICAL HISTORY

Name of Physician _____ City _____ Phone _____

Do you have a current medical problem? Yes _____ No _____ If so, what? _____

Do you have, or have ever had:	Yes	No		Yes	No
Lung trouble (TB, Asthma, Emphysema, or sinus)	_____	_____	VD (Syphilis, Gonorrhea, Herpes)	_____	_____
Rheumatic Fever	_____	_____	Are you pregnant (women only)	_____	_____
Hepatitis, liver disease	_____	_____	Radiation treatments	_____	_____
Diagnosed HIV Positive	_____	_____	On a salt-free diet	_____	_____
Arthritis, (you or your family)	_____	_____	Kidney problems	_____	_____
Blood Pressure (circle one) High Low Normal	_____	_____	Swollen ankles or feet	_____	_____
Diabetes, (you or your family)	_____	_____	Heart condition	_____	_____
Fainting spells	_____	_____	Allergies (medications, metals or others)	_____	_____
Excessive Bleeding	_____	_____	Joint Prosthesis	_____	_____
Convulsions, Epilepsy	_____	_____	Heart Murmur	_____	_____
			Prescription diet pills	_____	_____

Are you using any medications currently? _____

If so, what? _____

Date of last physical _____

Is there anything about your medical history we should know? _____

If so what? _____

I GIVE MY CONSENT TO USE LOCAL ANESTHETIC, NITROUS-OXIDE ANALGESIA OR RELAXANTS, AS NEEDED TO PROPERLY COMPLETE THE NECESSARY DENTAL WORK.

Signed (Patient or parent of minor) _____ Date _____

DENTAL EXCELLENCE FINANCIAL POLICY

- **Payment is expected as services are rendered.**
- For your convenience, we accept VISA, MASTERCARD and DISCOVER.
- Appointments broken without 24 hour notice will incur a minimum \$75 charge.
- We require 50% down on all work involving laboratory services.
- Further information regarding financial options may be obtained from our Financial Coordinator or Office Manager.

In consideration of the dental consultation and/or services to be provided to me or a member of the family, I agree to make full payment for services rendered. I understand that any contract for dental insurance coverage is a separate contract. In the event of non-payment or non-coverage by dental insurance, I agree that I am ultimately responsible for all charges on my account. In the event that this account is turned over to an attorney for collection, I agree to make all payment of all costs of collection, legal expenses and reasonable attorney's fees incurred by Dental Center.

Signed (Patient or parent of minor) _____ Date _____

(OFFICE USE)

Recall Medical History

I have reviewed my medical history and there is no change (or changes as noted)

Signed _____	Date _____	Hyg _____	Signed _____	Date _____	Hyg _____
Signed _____	Date _____	Hyg _____	Signed _____	Date _____	Hyg _____
Signed _____	Date _____	Hyg _____	Signed _____	Date _____	Hyg _____
Signed _____	Date _____	Hyg _____	Signed _____	Date _____	Hyg _____
Signed _____	Date _____	Hyg _____	Signed _____	Date _____	Hyg _____