



PATIENT INFORMATION

Today's Date _____

Patient's Name Last: _____ First: _____ Middle Initial: _____

Soc. Sec.#: _____ Birth Date: _____ Age: _____ SEX: M/F

If patient is a minor, give parent's or guardian's name: _____

How did you hear about our office? (✓ Check all that apply)

- Radio Ad Co-Worker Web Page or Search Engine Insurance Provider Listing Other
- Word of Mouth Friend/Family Member Smithville Telephone Book SBC Yellow pages Yellow Book

Is there someone we should thank for referring you to our practice? If so, please tell us their name _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First: _____ Middle Initial: _____ Birth Date: _____ SEX: M/F

Soc. Sec.#: _____ Relationship to Patient: _____ Marital Status: Single Married Divorced Widowed

RESIDENCE Street Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Work: () _____ Cell : () _____ e-mail _____

EMPLOYER _____ OCCUPATION _____ # of Years Employed There _____

RESPONSIBLE PARTY'S SPOUSE

Name: _____
Last First Middle

Employer _____ # of Years Employed There _____

Occupation _____ Soc. Sec # _____

Work Phone: () _____ Birth Date: _____

**EMERGENCY INFORMATION:
RELATIVE NOT LIVING WITH YOU**

NAME _____

ADDRESS _____

CITY, STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name: _____ Birth Date: _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Ins ID # _____ Soc Sec # _____

Group # _____ Insurance Inquiry Phone # _____

If you have double dental insurance coverage, complete this section for the secondary provider

Insured's Name: _____ Birth Date: _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Ins ID # _____ Soc Sec # _____

Group # _____ Insurance Inquiry Phone # _____

PATIENT MEDICAL HISTORY

Name _____ Date of birth _____

Do you have any CURRENT HEALTH PROBLEMS? Yes No

Are you currently under a PHYSICIAN'S CARE? Yes No

If yes, for what? _____

What MEDICATIONS (including over the counter) do you take? _____

What SUPPLEMENTS (including herbal) you you take? _____

Women: Are you PREGNANT? No Yes, due date: _____
Do you take BIRTH CONTROL PILLS? Yes No

Do you SMOKE or use OTHER TOBACCO PRODUCTS? Yes No
of packs per day: _____

✓ CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR PRESENTLY HAVE:

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints or Prosthesis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pre-medicate |
| <input type="checkbox"/> Pain in Jaw or Joints | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Ailments | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | | |

CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE A KNOWN ALLERGY TO or HAVE HAD AN ADVERSE REACTION TO:

Codeine Erythromycin Latex Local Anesthetic
Penicillin Sulfa

Are you aware of being allergic to any other medications or substances? Yes No
If yes, please list all known allergies: _____

Do you take any blood thinners (i.e. Coumadin or Plavix) that may need to be discontinued prior to dental treatment?
Yes No

Is there any other MEDICAL or DENTAL information that we should be aware of? Yes No

YOUR REGULAR PHYSICIAN'S NAME and PHONE NUMBER _____

PATIENT DENTAL HISTORY

How Long Since you have seen a dentist? _____
Is your present dental health GOOD FAIR POOR

Are you having any dental problems now? Yes No

Are you afraid or nervous about dental treatment? Yes No

Do your gums BLEED, feel TENDER or IRRITATED? Yes No

Are you UNHAPPY with the APPEARANCE of your teeth? Yes No

Do you have HEADACHES, EARACHES, or NECK PAIN? Yes No

Do you have DISCOLORED teeth that you are unhappy with? Yes No

Would you like your smile to LOOK BETTER or DIFFERENT? Yes No

Do you REGULARLY use DENTAL FLOSS? Yes No

In general, how do you feel about your teeth? _____

Appointments— Our office takes pride in the fact that we run on time and try to be as efficient as possible. We expect that our patients will be equally as courteous. If you are late for an appointment, our office will make an effort to be sure that you are seen, if time allows. Otherwise, the appointment will need to be rescheduled. **We request that you give 48 hour notice if you are unable to make your scheduled appointment.** If you fail an appointment or re-schedule a procedure multiple times, our office reserves the right to request that you seek services elsewhere.

FINANCIAL POLICIES

- FINANCE CHARGE**- I agree to pay up to 1.5% per month (18% Annual Percentage Rate) on any balance over 60 days old.
- BILLING CHARGE**- I agree to pay up to \$5 per month for billing costs, if any balance remains beyond 60 days from the date services are rendered.
- COLLECTION COSTS**- I agree to pay any **attorney fees, court costs**, and a 35% Collection Fee if collection by a third party is necessary.
- BAD CHECK CHARGE**- I understand that a \$25 charge will be added to my balance if any check is returned for insufficient funds. Further, I agree to pay my total balance by cash or money order with in 10 days check's return to the office of David C. Walden.
- RESPONSIBLE PARTY**— The parent/guardian who presents a **minor child** for treatment is responsible for payment of the account, regardless of any court orders stating otherwise, unless written permission to bill another party is presented to our office at the time of service.
- INSURANCE**— If I am insured, I realize that the dental office will file my claim as a courtesy to me. I agree to remit payment of my balance in full in the event that my insurance company denies or delays payment after 60 days from when the service is rendered. I also realize that most insurance plans do not cover 100% of the cost of dental treatment. **I acknowledge that I am responsible for any patient portion and agree to pay the estimated amount at the time of service.** I know that this estimate is not a guarantee of payment on the part of my insurance company and that I may be responsible for a different amount than I have been quoted.

The information I have given today is correct to the best of my knowledge. It is my responsibility to **inform** this office of any changes in medical status. I hereby authorize the dental staff to **perform any necessary dental services** with my informed consent that may be needed during diagnosis and treatment. I authorize the **release of any information** including the diagnosis and records rendered to me or my child to **insurance companies and/or other health practitioners**. I authorize and request my insurance company to **pay directly to the dentist** benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to pay any amount not covered. **I understand the financial policies** and agree to be **responsible for payment** of all services rendered to me or my dependants.

SIGNATURE of PATIENT or RESPONSIBLE PARTY:

Date: _____