Aliso Park Dental Patient Information Sheet

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Patient Name:	Date:						
Last	First MI ☐ Married ☐ Single ☐ Child ☐ Other						
☐ Male ☐ Female							
II .							
Phone (Home):	(Work):	Ext: Best time to	call:				
Address:							
Street	Apartment #						
City	State		Zip Code				
Health Information							
Date of Last Dental Visit: Reason for this visit: Have you ever had any of the following? Please check those that apply: Yes No Yes No Yes No							
O O AIDS	O O Excessive Bleeding	O O Latex Allergies	O O Steroid Medication(s)				
O O Alcoholism	O O Epilepsy	O O Liver Disease	O O Stomach Problems				
O O Allergies	O O Fainting	O O Mental Disorders	O O Stroke				
O O Anemia	O O Glaucoma	O O Mitral Valve Prolapse	O O Thyroid Disease				
O O Arthritis	O O Growths	O O Nervous Disorders	O O Tuberculosis				
O O Artificial Joints	O O G-6PD Deficiency	O O Pacemaker	O O Tumors				
O O Asthma	O O Hay Fever	O O Painful Joints (incl. jaw)	O O Ulcers				
O O Blood Disease	O O Head Injuries	O O Penicillin Allergy	O O Venereal Disease				
O O Blood Transfusions	O O Heart Disease	O O Persistent Cough	Other:				
O O Bruise or bleed easily	O O Heart Murmur	O O Phen-Fen	Do you smoke?				
O O Cancer	O O Heart Problems/Angina	O O Prosthetic Heart Valves	O Yes O No				
O O Codeine allergy	O O Heart Surgery	O O Prosthetic Joint(s)					
O O Cold sores (herpes)	O O Hemophelia	O O Radiation Treatment	i anami le				
O O Congenital Heart Lesions	O O Hepatitis	O O Respiratory Problems					
O O Diabetes	O O High blood pressure	O O Rheumatic Fever					
O O Dizziness	O O Hives	O O Rheumatism					
O O Drug Addiction	O O Hypertension	O O Sickle Cell Disease					
O O Emphysema	O O Jaundice	O O Sinus Problems					
	O O Kidney Disease						
	mplications following dental tre	atment? ☐ Yes ☐ No					
If yes, please explain:	a hospital or needed emerger	any care during the next two was	om2 TVon TNo				
 Have you been admitted to If yes, please explain: 	a nospitator needed emerger	icy care during the past two yes	als: LITES LINO				
	e of a physician?	No					
	e or a physician: — Tes — T						
Name of Physician:		Phone:					
Medications Currently Being	Taken						
 Do you have any disease, condition, or problem not listed above? ☐ Yes ☐ No If yes, please explain: 							
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have							
any changes in my health, I will inform the doctors at the next appointment without fail.							
Signature of patient, parent or gu	ardian D	entist Signature	Date				
Medical History reevaluation			Comments:				
Medical History reevaluation	(Dentist signature)	Date:	Comments:				
P							
14/1		al Information					
	ferring you to our practice? Delta DentalIn		Dental Office PPO List				

The following is for: the patient's spouse	Spouse or Response the person response		Intormation			
H .	□Ma	arried U Single	□ Child □ Other			
Social Security #:		Birth Date:				
Phone (Home):	_ (Work):	Ext:	Best time to ca	ll:		
Address:		· · · · · · · · · · · · · · · · · · ·		Apartment #		
City			State	Zip Code		
The following is for:	the person respons					
Employer Name:	-		on:			
Address:		City	State	Zip Code		
Caeca		3.19		1		
Insurance Information						
Name of Insured:			Is insured a par	tient? □ Yes □ No		
Insured's Birth Date:	First ID #:					
Insured's Address:						
Insured's Employer Name:		City	State	Zip Code		
Address:						
Street Patient's relationship to insured	: D Self D Spouse	City Child Oth	State	Zip Code		
Insurance Plan Name and Address						
Secondary Name of Insured			Is insured a pa	tient? [] Ves [] No		
Name of Insured:	First	MI				
			Group #			
Insured's Address:sireet Insured's Employer Name:		City	State	Zip Code		
Address:				,		
Street Patient's relationship to insured	: Self Spouse	city Child Oth	State PCT	Zip Code		
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 11% 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 car In consideration for the professional services rendered to	me, or at my request, by the Doct	or I agree to pay therefore ti	he reasonable value of said service	es in said Daylor, or his analogue at the sti		
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.						
Signature of patient, parent or guardian	Da	ate:	Relationship to Patient: _			
The state of the s		nto	Deletionable to Detical			
Date: Relationship to Patient: Signature of guarantor of payment/responsible party						