CONFIDENTIAL PATIENT INFORMATION

Date _____

PATIENT: Name _____ (Last) (First) (Middle) (Home Phone #)

Address _____ (Street) (City) (State) (ZIP)

Place of Employment _____ Occupation _____

Business Address _____ (Street) (City) (State) (ZIP) (Business Phone#)

Date of Birth _____ SS# _____ Male ❑ Female ❑

Height: ___ ft. ___ in. Weight _____ lbs. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Hobbies _____

SPOUSE: Name _____ And Address if different from above

Place of Employment _____ Occupation _____

Business Address _____

Person Responsible for Account _____ And Address if different from above

Whom may we thank for referring you to our office? _____

Has any member of your family been treated in our office previously? Yes ❑ No ❑ (Relationship) _____

Why did you choose Dr. Sims as your dentist? _____

Reason for Visit: _____

DENTAL HEALTH: Please check one: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

What priority do you give your teeth (10 being highest)? 1 2 3 4 5 6 7 8 9 10

DENTAL INSURANCE: Please complete the following confidential information regarding Dental Insurance:

Primary Carrier Insurance Company _____

Mailing Address _____

Employee _____ SS# _____ Group # _____

Secondary Carrier Insurance Company _____

Mailing Address _____

Employee _____ SS# _____ Group # _____

MEDICAL HEALTH: Please check one: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Physician's Name _____

Last complete physical? _____ Are you under a doctor's care now? _____

If yes, for what reason? _____

Please list any medications, pills or drugs you are taking _____

_____

Have you ever received a blood transfusion? Yes ❑ No ❑ When? _____

Are you subject to fainting spells? Yes ❑ No ❑ Are you pregnant? Yes ❑ No ❑ How long? _____

Are you subject to prolonged bleeding? Yes ❑ No ❑

(over)

MEDICAL HEALTH: (continued)

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Local anesthetics ❑ Other medications - list below:

_____

Please CIRCLE if you have or have had any of the following:

Heart Trouble	Fainting or Dizziness	Hepatitis B (serum)
High Blood Pressure	Stroke	Recent Weight Loss
Low Blood Pressure	Diabetes	Cancer
Heart Murmur	Artificial Joints/Hips	Thyroid Disease
Rheumatic Fever	Kidney Trouble	Parathyroid Disease
Congenital Heart Lesion	Ulcers	X-Ray or Cobalt Tmt.
Artificial Heart Valve	Allergies	Chemotherapy/Radiation
Heart pacemaker	Asthma	Arthritis/Gout
Heart Surgery	Hay Fever	Glaucoma
Mitral Valve Prolapse	Sinus Trouble	Epilepsy or Seizures
Blood Disease	Emphysema	Alzheimer's Disease
Anemia	Frequent Cough	Hypoglycemia
Chest Pain	Lung Disease	Psychiatric Care
Shortness of Breath	Liver Disease	Hemophilia
Swelling of Feet/Ankles/Hands	Hepatitis A (infec.)	HIV Positive

Have you ever had any serious illness not circled above? ❑ Yes ❑ No Please describe in detail. _____

_____

_____

Do you wish to talk to the doctor privately about any problem? ❑ Yes ❑ No

I will allow Dr. Sims to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow him permission to discuss my conditions with my physician and to request medical information from him.

_____ **Patient's Signature**

_____

Reviewed by: Doctor _____ Date _____

MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated ____ and confirm that it adequately states past and present conditions.

Date	Exceptions		Patient's Signature	Reviewed By
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____
_____	_____	None ❑	_____	_____

Responsible Party Information

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____

Address: _____
Street Apartment # City State Zip Code

In case of emergency, whom shall we call: **Name** _____ **Relationship** _____

Phone Numbers: _____

Insurance Information

Primary Insured Persons Information:

Name: _____ Birth Date: _____ ID or SS#: _____
Last First MI

Address: _____
Street City State Zip Code

Employer Name & Address: _____ Group#: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Phone Number: _____

Secondary Insured Persons Information:

Name: _____ Birth Date _____ ID# _____
Last First MI

Address: _____
Street City State Zip Code

Employer Name & Address: _____ Group#: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name & Phone Number: _____

Consent for Services

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 30 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

IT IS OUR POLICY TO CHARGE $80.00 PER HOUR FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS

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.

X _____ **Date:** _____ **Relationship to Patient:** _____

Signature of Responsible Party / Parent or Guardian

In order for us to help prepare your insurance forms and assist in making collections from insurance companies , we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims.

X _____

Signature of Responsible Party/Parent or Guardian