Patient Information

Patient Name: ____ Date: _______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Social Security #: ___________________________ Birth Date: ____________________

Cell Number: ___________________ Work #: __________________ ALTERNATE #: _________________

E-Mail Address: ____________________________________

Address: ____
Street Apartment # **SCHOOL DISTRICT**

____
City State Zip Code

*****How did you hear about us/who referred you? : ____________________________________

Date of Last Dental Visit: ________________________

Please check all CURRENT medical conditions:

- ☐ ADHD/ADD
- ☐ AIDS/HIV

WRITE down all known ALLERGIES:

____
____
____

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer: __________
- ☐ Diabetes: Type _____
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Facial Trauma
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths/Tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ List Mental/Nervous Disorders: ________________
- ☐ Pacemaker
- ☐ Pregnant: Due date _________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Do you Smoke? ____

Other CONDITIONS we should be aware of:

☐ ________________

☐ ________________

List any medications being taken at this time:

____

____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Do you need to **PRE-medicate with antibiotics** before any dental treatment due to a medical condition? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No

Name of Physician: ______________________________ Phone: _________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor/office at the next appointment without fail.

____ Date: _________________

Signature of patient, parent or guardian

Employment Information

The following is for: ☐ Me, the patient ☐ Insurance Subscriber

Employer Name: ___________________________________ Occupation: _______________________________

Insurance Subscriber Information

Name of Subscriber: _________________________________ Subscriber's Birth Date: ____________________

Cell Number: ____________________________ Home Number: _________________________

Address: ____
Street Apartment #

____
City Zip Code

Insurance Plan Name: ____

Member ID # or Social Security #: ___________________________________ Group #:
____

Insured's Employer Name: ____

Consent for Services & Payment Agreement

As a condition of your treatment by this office, financial arrangements will/must be made in advance. The practice depends upon reimbursement from the patients or patients insurance for the costs incurred for their care. It is the responsibility of the patient/responsible party to attend scheduled appointments. We reserve ample time to provide our patients with the service and care they deserve and understand our patients are not always in total control of their schedules. Patients will receive electronic reminders before any scheduled appointment (if no electronic device is available, you will be contacted by phone).

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 carefully *ESTIMATE* co-pays/payment responsibility and prepare the patients insurance forms and assist in collecting from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me, at my request, or by the Doctor, I agree to pay the co-pay of said services to said Doctor, at the time said services are rendered. 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. All emergency dental services (when office is closed), or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

I grant my permission to your office to telephone me at the numbers I provided to discuss matters related to these forms. I understand co-pays and any unpaid balances are the responsibility of the patient/responsible party. I have read, understand and agree to the above conditions for treatment and payment.

____ _________________ ____________________

Paul Ro, DDS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, (PRINT NAME) ______________________________, have read a copy of this office's

Notice of Privacy Practices.

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement