

URGENT DENTAL

Quality dental care. When you need it.

Patient Information	Date _____
Name: _____ I Prefer to be called: _____	
Address: _____ City: _____ State: _____ Zip _____	
Home (____) _____ Work (____) _____ Cell/Mobile (____) _____	
Date of Birth: _____ Social Security Number: _____	
Check Appropriate Box: <input type="checkbox"/> Minor/Child <input type="checkbox"/> Single <input type="checkbox"/> Married	
Employer: _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT	
Spouse or Parent's Name: _____ Employer _____ Work Phone _____	
How did you hear about our office? _____	
Person to contact in case of emergency _____ Phone _____	

Insured or Responsible Party Information
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Name: _____ Relationship to Patient: _____
Address: _____ DOB _____
City: _____ State: _____ Zip: _____ Phone: (____) _____
Employer _____ Work Phone (____) _____ SSN# _____

Insurance Information
Name of Insured _____ DOB _____ Relationship to Patient _____
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____ City _____ State: _____ Zip _____
Insurance Co Name _____ Group # _____ ID# _____
Ins Co Address: _____ Ins Co. Phone: _____
----- DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING -----
Name of Insured _____ DOB _____ Relationship to Patient _____
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____ City _____ State: _____ Zip _____
Insurance Co Name _____ Group # _____ ID# _____
Ins Co Address: _____ Ins Co. Phone: _____

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Medical History

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Pre-Med – Amoxicillin
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Cancer
<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> HIV
<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Sinus Problem
<input type="checkbox"/> Tumors
<input type="checkbox"/> Allergy – Aspirin
<input type="checkbox"/> Allergy – Codeine
<input type="checkbox"/> Allergy – Other, Please List | <input type="checkbox"/> Pre-Med – Clindamycin
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Fainting
<input type="checkbox"/> Heart Murmur / MVP
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Respiratory Problem
<input type="checkbox"/> Stomach Problem
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Allergy – Ibuprofen
<input type="checkbox"/> Allergy – Latex, Metal, Plastic | <input type="checkbox"/> Pre-Med – Other
<input type="checkbox"/> Asthma
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Stroke
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Allergy – Sulfa Drugs
<input type="checkbox"/> Allergy – Novocaine | <input type="checkbox"/> Anemia
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other – Please List
<input type="checkbox"/> Allergy - Penicillin
<input type="checkbox"/> Allergy – Epinephrine |
|---|---|---|---|

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.

Patients with dental insurance understand that in some cases, all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit the collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balances will be charged on all accounts, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

- I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____