PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Patient's Name____Nickname ______________
Last First Initial

Residence Address____
Street City Zip

Patient is: ❑ Male ❑ Female ❑ Married ❑ Single ❑ Minor Occupation ______________________

Date of Birth_______________ Soc. Sec._____________________ Local Res. Phone ( ) ______________

Employed by____ Other Residence ( ) ______________

Business Address ____________________________________ Business Phone ( ) ______________

Spouse's Name ______________________________________ Pager/Cell ( ) ______________

Emergency contact (not living with you)__________________ Phone ( ) ______________

Whom may we thank for referring you?___________________ Email Address___________________

Physician ____
Name Address City Phone

Please list your main dental concern ____

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Medical History

1. Are you in good health? Yes No
2. Date of last physical examination ______________________________
3. Are you under the care of a physician? Yes No
   If so, what is the condition being treated? ______________________________
4. Have you ever had any serious illness or operation? Yes No
   If so, what illness or operation? ______________________________
5. Have you ever been hospitalized? Yes No
   If so, what was the problem? ______________________________
6. Are you taking any drugs or medicine? Yes No
   If so, what? ______________________________What dosage?______________
7. Are you sensitive or allergic to any drugs or medication? Yes No
   ❑ Penicillin ❑ Tetracycline ❑ Aspirin ❑ Sulfa Drugs ❑ Codeine ❑ Other___________________
8. Do you have or have you had any of the following: (Please ☒ known conditions)

❑ Aids Related Complex	❑ Cold Sores	❑ Heart Failure	❑ Premedicate before Treatment
❑ Allergy or Hives	❑ Congenital Heart Lesions	❑ Heart Murmur	❑ Psychiatric Treatment
❑Allergy - Rubber/Latex	❑ Diabetes	❑ Hemophilia	❑ Radiation Treatment
❑ Anemia	❑ Difficulty in Swallowing	❑ Hepatitis or Jaundice	❑ Respiratory Disease
❑ Angina Pectoris	❑ Drug Addiction	❑ Herpes	❑ Rheumatic Fever
❑ Arthritis	❑ Dry Mouth	❑ High Blood Pressure	❑ Rheumatism
❑ Artificial Heart Valves	❑ Emphysema	❑ HIV Positive	❑ Scarlet Fever
❑ Artificial Prosthesis	❑ Epilepsy or Seizures	❑ Joint Replacement	❑ Sinus Trouble
❑ Asthma	❑ Excessive Bleeding	❑ Kidney Disease	❑ Stomach Ulcers
❑ Blood Disease	❑ Fainting Spells	❑ Liver Disease	❑ Stroke
❑ Blood Transfusion	❑ Glaucoma	❑ Mental Disorder	❑ Thyroid Disease
❑ Bruises Occur Easily	❑ Hay Fever	❑ Mitral Valve Prolapse	❑ Tuberculosis
❑ Cancer	❑ Head Injuries	❑ Nervous Disorders	❑ Tumors or Growths
❑ Chemotherapy	❑ Heart Ailments or Attack	❑ Pain in Jaw Joints	❑ Venereal Disease

9. Do you wear a cardiac pacemaker, or have you had heart surgery? Yes No
10. Do you have any disease, condition or problem not listed that you think I should know about? Yes No
    If yes, please explain______________________________
11. Do you use tobacco? ❑ Smoker ❑ Chewing Tobacco ❑ If yes, how many per day?____________ Yes No
12. ❑ Are you pregnant? ❑ Are you nursing ❑ Do you take birth control pills? Yes No

Dental History

1. Have you ever had a local anesthetic (Novocaine, etc.)? Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
3. Have you had any serious trouble associated with any dental treatment? Yes No
4. How long since your last dental treatment?______________________________
5. Are you happy with your smile? If not, why? ______________________________ Yes No
6. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

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

Date______________Signature/Guardian______________________________Reviewed by ________, DMD

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FOR OFFICE USE ONLY – PLEASE DO NOT WRITE IN THIS SPACE

I have reviewed the medical history and to the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

	REVIEWED BY
Exam 2 Changes in Health ____________________ Date__________ Signature____________________	___________
Exam 3 Changes in Health ____________________ Date__________ Signature____________________	___________
Exam 4 Changes in Health ____________________ Date__________ Signature____________________	___________

	Date	BP	Initials
Exam 1			
Exam 2			
Exam 3			
Exam 4			

FINANCIAL INFORMATION

Person responsible for this account________________________ Relationship______________

Address____

Street City Zip Telephone

Do you have dental insurance? ❑ Yes ❑ No

Employee Name: ______________________ SS# ______________ Date of Birth__________

Please present your insurance card and a completed insurance form to our receptionist. Thank you.

I authorize release of any information relating to all dental claims and understand that I am responsible for all costs of dental treatment regardless of my insurance coverage. I hereby authorize payment of the dental benefits otherwise payable to me directly to Izu and Bergmann Dental Associates, Inc.

Signed ____ Date ______________

TERMS & CONDITIONS

As a condition of treatment by this office I understand financial arrangements must be made in advance. The Practice depends upon reimbursement from the patient for the costs incurred for dental 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 at the time 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. This dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1-1/2% 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 60 days of treatment date. On financial contracts, a service charge of 1-1/2% per month (18% per annum) will be charged after 30 days on the unpaid principal balance. A $3.00 late charge will apply on financial contract accounts that are delinquent.

I understand that the fee estimate listed for this dental care can only be extended for a period of 8 months from the date of the doctor's diagnosis.

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

Signed____ Date ____________

CONSENT FOR TREATMENT

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that I will be informed of all possible complications of the procedures, anesthetics and/or drugs, before undergoing treatment.

"All services are rendered and accepted under the terms and conditions"

Signed:____ Date__________

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to Patient: ______________________________

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