

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Age: _____

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

Email: _____ Driver's License # & State: _____

Address: _____
Street Apartment #

City State Zip Code

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code P

Health Information

Reason for your visit today: _____ Date of Last Dental Visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|---|---|---|
| ☐ AIDS/HIV | ☐ Excessive Bleeding | ☐ Kidney Disease | ☐ Sinus Problems |
| ☐ Allergies _____ | ☐ Fainting | ☐ Lung/Bronchial Condition | ☐ Stomach Problems |
| ☐ Penicillin Allergy | ☐ Frequent Nose Bleeds | ☐ Liver Disease | ☐ Stroke |
| ☐ Codeine Allergy | ☐ Gall Bladder Trouble | ☐ Mental Disorders | ☐ Tuberculosis |
| ☐ Anemia | ☐ Glaucoma | ☐ Nervous Disorders | ☐ Tumors |
| ☐ Arthritis | ☐ Growths | ☐ Pacemaker | ☐ Ulcers |
| ☐ Arthritis | ☐ Goiter or Thyroid Disorder | ☐ Pregnant NOW | ☐ Venereal Disease |
| ☐ Artificial Joints | ☐ Hay Fever | Due date: _____ | ☐ Unexplained Night Sweats |
| ☐ Asthma | ☐ Head Injuries | ☐ Radiation Treatment | OTHER: _____ |
| ☐ Bladder Trouble | ☐ Heart Problems | ☐ Respiratory Problems | ☐ _____ |
| ☐ Blood Disease | ☐ Heart Murmur | ☐ Rheumatic Fever | ☐ _____ |
| ☐ Cancer | ☐ Hepatitis | ☐ Rheumatism | ☐ Are you a Smoker? |
| ☐ Convulsions | ☐ High Blood Pressure | ☐ Skin Disease | |
| ☐ Diabetes | ☐ High Cholesterol | | |
| ☐ Dizziness | ☐ Jaundice | | |
| ☐ Epilepsy | | | |

☒ Have you ever had any complications following dental treatment or been told not to take an injection for dental purposes?
☐ Yes ☐ No If yes, please explain: _____

☒ Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

☒ PREFERRED PHARMACY: _____ Emergency Contact Name & Number _____

☒ Are you now on any medications ☐ Yes ☐ No PLEASE LIST ALL MEDICATIONS ON THE BACK OF THIS PAGE.

☒ Name of Physician: _____ Phone: _____

☒ Have you ever had a major operation or do you have any health problems that need further clarification? ☐ 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 change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Spouse Information or if patient is a child the Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payments

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Pager: _____ (Cell phone): _____

Address: _____

Street

Apartment #

City

State

Zip Code

Spouse Information or if patient is a child the Responsible Party Employment Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Phone

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last

First

MI

Insured's Birth Date: _____ SS # _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

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

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

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

Insurance Plan Name and Address: _____

Emergency Information

Name of Person at a different address: _____ Relationship: _____

Last

First

MI

Address: _____

Street

City

State

Zip Code

Phone (Home): _____ (Work): _____ (Cell phone): _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

CONCERNING FINANCIAL ARRANGEMENTS...

Our entire office is dedicated to providing you with the best possible care. If you have dental insurance we want to help you receive your allowable benefits.

We request payment to be made at the time services are rendered unless arrangements have been made in advance. You may pay by cash, check, Master Card, Visa, Discover or American Express. We will assist you in processing your insurance claim form for reimbursement.

Balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½% per month. Charges may also be made for broken appointments.

It is important you realize that your insurance contract is between you, your employer and the insurance company. We are not a party to the contract. Even though we will assist you in filing your insurance claim, **all charges are your responsibility.**

We realize certain unforeseen financial problems may affect timely payment of your account. If such problems arise, please contact us for assistance in the management of you account.

If you have any questions, please don't hesitate to ask us. Thank you.

AUTHORIZATION AND AGREEMENT FOR ALL MEMBERS OF YOUR FAMILY

1. I authorize and assign payments directly to Magnolia Dental Associates for insurance benefits, including major medical, payable under the terms of my insurance contract.
2. I authorize Magnolia Dental Associates to release information acquired in the course of treatment, including information necessary for the processing of insurance claims and inquiries, for insurance companies listed above.
3. I authorize copies of this form to serve as valid originals.
4. I accept full liability and responsibility for payment of all amounts due to Magnolia Dental Associates for services rendered. Non-payment by an insurance company or payment arrangements in divorce order do not relieve my/your primary obligation to pay the above full amount.
5. I agree that if any amount under this agreement remains unpaid and is referred to an attorney for collection, I shall pay a reasonable attorney's fee and all costs of collection.

YOUR SIGNATURE ON THIS AGREEMENT CONSTITUTES LEGAL AUTHORIZATION AND A LEGAL AGREEMENT TO PAY. I ACKNOWLEDGE THAT I HAVE READ, AND UNDERSTAND AND ACCEPT THIS AGREEMENT.

WE REQUIRE 24 HOUR NOTICE TO CANCEL APPOINTMENTS. THERE WILL BE A CHARGE FOR MISSING, CHANGING OR CANCELLING APPOINTMENTS WITH LESS THAN A 24 HOUR NOTICE.

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____