21st Century Dental

Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Parent/Guardian Name: _____ _____

Health Information

Date of Last Dental Visit: _____

Has child ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Chemical Dependencies
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Tonsils still present?
- ☐ Teeth Grinding at night
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Transplant/Prostheses

Is child currently pregnant? ☐ Yes ☐ No
If so, due date:_____

Drug Allergies:
_____
_____
_____
_____
Recent Surgeries?_____

- Has child ever had: (check all that apply)
  ☐ Cavities ☐ Toothache ☐ Mouth Pain ☐ Extracted Teeth ☐ Gum Infection ☐ Braces: Dr._____
- Has child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of primary Physician: _____ Phone:_____
- Does the child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Medications child is taking:_____
- Child's interests and hobbies:_____

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.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

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

Insurance Information

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

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

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Dental insurance company name: _____

Consent for Services

As a condition of your treatment by this office, 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.

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 help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 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.

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