Four Corners FAMILY DENTISTRY

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name_____
Last, First MI (Preferred Name)

Gender ☐ Male ☐ Female Marital Status: _____

Social Security #: _____ Birth Date_____

Phone (Primary): _____ (Secondary): _____

Email: _____

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit_____ Reason for this visit: _____

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

☐ AIDS	☐ Fainting	☐ Liver Disease	☐ Stomach Problems
☐ Anemia	☐ Glaucoma	☐ Mental Disorders	☐ Stroke
☐ Arthritis	☐ Growths	☐ Nervous Disorders	☐ Tuberculosis
☐ Artificial Joints	☐ Hay Fever	☐ Pacemaker	☐ Tumors
☐ Asthma	☐ Head Injuries	☐ Pregnancy	☐ Ulcers
☐ Blood Disease	☐ Heart Disease	Due date:_____	☐ Venereal Disease
☐ Cancer	☐ Heart Murmur	☐ Radiation Treatment	OTHER:
☐ Diabetes	☐ Hepatitis	☐ Respiratory Problems	☐ _____
☐ Dizziness	☐ High Blood Pressure	☐ Rheumatic Fever	
☐ Epilepsy	☐ Jaundice	☐ Rheumatism	☐ _____
☐ Excessive Bleeding	☐ Kidney Disease	☐ Sinus Problems	

- Have you ever had any complications following dental treatment? ☐ 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: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any allergies that we need to be aware of? ☐ Yes ☐ No
  If yes, please list: _____

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? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Post Card ☐ Newspaper ☐ School ☐ Work ☐ Other _____

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

Spouse or Responsible Party Information

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

Name _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Insured's Employer Name: _____

Insurance Plan Name: _____

Member ID#: _____

Address: _____

Phone #: _____

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

Secondary

Insured's Employer Name: _____

Insurance Plan Name: _____

Member ID #: _____

Address: _____

Phone #: _____

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

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.

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.

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.

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

I understand that the fee estimate listed 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, 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

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party