

Patient Information

Patient Name: _____ Date: _____
Last, First MI

Male Female / Married Single Child Other Spouse's Name / Work # _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell/Pager #: _____

Address: _____
Street Apartment #

_____ City State Zip Code

Employer: _____ Occupation/Position: _____

Employer's Address: _____

Person we should contact in case of an emergency: _____
(nearest relative/friend not living with you) Name Relationship Phone Number

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach Problem/Ulcers |
| <input type="checkbox"/> Allergies: | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Latex <input type="checkbox"/> Penicillin | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> TMJ/Jaw Joint Pain |
| <input type="checkbox"/> Sulfa <input type="checkbox"/> Codeine | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Kiwi <input type="checkbox"/> Bananas | <input type="checkbox"/> Glaucoma | Due: _____ | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chestnuts <input type="checkbox"/> Avocado | <input type="checkbox"/> Heart - MVP | <input type="checkbox"/> PRE-MED | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Other Allergies: _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | OTHER: |
| <input type="checkbox"/> Anemia/Hemophilia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rashes/Hives | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Smoke | |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Spine Bifida | |
| | <input type="checkbox"/> Low Blood Pressure | | |

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Are you currently taking any drugs or medications? Yes No
If yes, please list: _____
- 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 health problems that need further clarification? Yes No
If yes, please explain: _____
- What would you change about your smile if you could?

To the best of my knowledge, all of the proceeding 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: _____

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: _____

Responsible Party Information (if other than patient)

The patient is considered the responsible party unless the patient is under 18 years of age. If the patient is a minor, the parent of legal guardian bringing the child to this office is considered the responsible party. In no case will we bill a third party (other than insurance) or a non-custodial parent for payment.

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell/Pager: _____

Address: _____
Street Apartment #
City State Zip Code

Employer Name: _____ Occupation: _____

Employer's Address: _____
Street City State Zip Code Phone

Insurance Information

The patient (or the parent/legal guardian, if the patient is over 18 years old) will be responsible for PAYMENT IN FULL on your initial visit. On any return visit, as a service to our patients, we will file your primary insurance for you provided we can get verbal verification and a break down of benefits from your insurance carrier prior to treatment. Once verification is received, we will calculate your co-payment based on the information provided by your insurance company and our past experience with your plan. We will then collect your estimated co-pay at the time services are rendered. Once actual insurance payment has been received, we will bill you or refund you any difference, whichever the case may be. Although we will file insurance claims for you as a courtesy, your entire balance is your responsibility and begins aging at the time services are rendered. If insurance payment has not been received within 30 days, you will be billed the balance and will be due upon receipt. WE DO NOT FILE SECONDARY INSURANCE CLAIMS nor will we wait for you to pay us with reimbursement from your secondary plan. We will be happy, however, to answer any questions you may have in order for you to file these claims.

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

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: _____

Insurance Co. Phone Number _____

Consent for Services

As a condition of your treatment by this office, I understand that payment in full is due at the time services are rendered. I may pay with cash, personal check (with approval), Visa, Mastercard, Discover or Debit Card. I understand that all emergency dental services or any services performed after regular business hours must be paid in cash at the time services are rendered.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts aged 30 days, regardless of pending insurance.

I understand that this office has the right to charge me for a failure to keep a reserved appointment or for canceling an appointment without 24 hour business days advanced notice.

I understand that the fee estimate given to me for any dental care is only an estimate and can only be extended for a period of six months from the date of the patient examination. I also understand that due to the nature of dental care and the unforeseen problems that may arise during treatment, fees and/or treatment may change.

In the event that my account becomes delinquent, I understand that future treatment will be delayed until the balance has been paid. I also understand that if my account becomes delinquent, I shall be responsible for attorney fees, collection agency fees, costs of collections, court costs, and/or other expenses and fees if necessary.

I authorize payment of dental benefits, otherwise payable to me, directly to Dr. Jerrold Goldsmith.

I grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient (parent or legal guardian if under 18) _____ Date: _____ Relationship to Patient: _____