Welcome

To Dr. Anderson's Oral Health Clinic

Please fill out the following information.
If you have any questions, please ask us. Thank you!

Patient Name:_____
Last First MI Preferred

qMale qFemale qMarried qSingle qChild qOther _____

Social Security #:_____Birth Date:___/___/_____

Phone(Hm):_____(Wk):_____Ext._____ DL#/St._____

Address:_____
Street Apt.#

_____
City State Zip Code

Responsible Party (Parent/Guardian):_____
qMale qFemale qMarried qSingle qChild qOther _____
Social Security #:_____Birth Date:___/___/_____

Phone(Hm):_____(Wk):_____Ext._____ DL#/St._____

Address:_____
Street Apt.#

_____
City State Zip Code

Health History Information:

Have you ever had any of the following? (Please check all that apply):

qAIDS	qDiabetes	qHeart Disease	qPacemaker	qTumors	qUlcers
qAllergies:_____	qDizziness	qHeart Murmur	qRadiation Treatment		qVenereal Disease
_____	qEpilepsy	qHepatitis	qRespiratory Problems		qCodeine Allergy
qAnemia	qExcessive Bleeding	qHigh Blood Pressure	qRheumatic Fever		qPenicillin Allergy
qArthritis	qFainting	qJaundice	qRheumatism		qOther:
qArtificial Joints	qGlaucoma	qKidney Disease	qSinus Problems		
qAsthma	qGrowths	qLiver Disease	qStomach Problems		q_____
qBlood Disease	qHay Fever	qMental Disorders	qStroke		
qCancer	qHead Injuries	qNervous Disorders	qTuberculosis		q_____

Are you currently pregnant? q Yes q No Due Date:_____

Have you ever had complications following dental treatment? q Yes q No

If yes, please explain:_____

Have you been admitted to a hospital or needed emergency care during the past two years? q Yes q No

If yes, please explain:_____

Are you under the care of a physician? q Yes q No

If yes, please explain:_____

Name of Physician:_____ Phone:_____

Do you have any health problems that need further clarification? q Yes q No

If yes, please explain:_____

What medications are you currently taking? _____

Insurance Information

Primary

Name of Insured:_____ Is insured a patient? qYes qNo
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: qSelf qSpouse qChild qOther _____

Insurance Plan Name and Address:_____

_____

Secondary

Name of Insured:_____ Is insured a patient? qYes qNo
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: qSelf qSpouse qChild qOther _____

Insurance Plan Name and Address:_____

_____

Employer Name:_____ Occupation:_____

Address:_____
Street City State Zip Code

Whom do we thank for referring you to our practice? qYellow Pages qDental Office qAnother Patient qWork qInsurance Company qOther:_____

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

To the best of my knowledge, all of the Health History 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

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 previous 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 is 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 agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I further agree to pay any collection fees (40% of balance) if a third party or collection agency is used by the said doctor to collect outstanding balances for said services ninety (90) days or more after services are rendered, unless previous written financial arrangement are satisfied.

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 consent.

_____Date:_____ Relationship to patient:_____
Signature of patient, parent or guardian

_____Date:_____ Relationship to patient:_____
Signature of guarantor of payment/responsible party

That's all Folks