Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

Address: ____
Street Apartment #

____
City State Zip Code

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ____ (Mobile): __________ E-Mail: __________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Please list two emergency contacts:

(Nearest relative *not* living with you)______________________ Relationship: __________ Phone#: ____________

(Nearest relative *not* living with you)______________________ Relationship: __________ Phone#: ____________

Health Information

Date of Last Dental Visit: ________________ Reason for this visit: ______________________________

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

☐ AIDS
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems

☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ ________________
☐ ________________

- Do your gums bleed? ☐ Yes ☐ No When? _____________ Do you grind/clinch your teeth? ☐ Yes ☐ No
- Do you have problems with food trapping between your teeth? ☐ Yes ☐ No Which teeth? _____________
- Do you use tobacco? ☐ Yes ☐ No If yes, do you ☐ Smoke ☐ Chew How often? _______________
- Do you hear popping or clicking noises when you chew? ☐ Yes ☐ No How often? _______________
- Have you ever had “laughing gas”? ☐ Yes ☐ No Would you like to try it in this office? ☐ Yes ☐ No
- Do you have any fear of having dentistry done? ☐ Yes ☐ No If yes, what bothers you? _____________
- Are you currently under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________________ Phone: _______________
- Please list any medication you are presently taking: ______________________________
- 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 doctor in writing 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 ☐ Another Dental Office

☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ______________________________

Name of *person* or *office* referring you to our practice: ______________________________

We are delighted to have you in our office and we will strive to do everything possible to keep you comfortable. Thank you for coming today. Philippians 4:6-7 in God’s Word tells us to “Be anxious for nothing, but in everything by prayer and supplication with thanksgiving, let your requests be made known to God, and the peace of God which surpasses all comprehension, shall guard your hearts and your minds in Christ Jesus.”

Spouse or Responsible Party Information

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

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ 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

Dental Insurance Information

Primary

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: ______________________________

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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: ______________________________

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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. It is understood that credit checks are a part of financial arrangements, and a copy of your credit report may be requested. Your signature is an authorization of this credit check.

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.

For our patients who are covered under a dental insurance plan, we will be happy to file the claim on your behalf and take your benefits on an assignment basis. This simply means that your insurance company will pay the claim directly to our clinic. We do this as a convenience for our patients. We would ask your cooperation in paying each visit the portion of your treatment not covered by insurance benefits. For our patients requiring extensive dental treatment, a confirmation of your insurance benefits will be obtained so that we may accurately advise you concerning your dental coverage.

Arrangements other than these will need to be discussed with our front office coordinator prior to treatment.

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. I give my full consent to Madison Dental Group, PLLC and its staff to render dental care to me and agree that I am ultimately the party responsible for paying and all fees incurred.

I have read the above conditions of treatment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ____________
Signature of patient, parent or guardian