Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

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

Gender: __________ Family Status: __________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ______ **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/HIV- Tcell count?
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cough- persistent
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Herpes
- ☐ Hepatitis Type _____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker/Defibrillator
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

Any Allergies:
☐ ________________
OTHER
☐ ________________

Medications List:

Health History

- Name of physician: ______________________
- Phone# __________ Last visit: ______________
- Do you smoke? ☐ Yes ☐ No If yes, How often: _______
- Do you use alcohol, cocaine, or other druges?☐Yes☐ No
If yes, please explain: ______________________
- WOMEN: Are you pregnant? ☐ Yes ☐ No Due date: ___
- WOMEN: Nursing? ☐ Yes ☐ No
- WOMEN: Taking an oral contraceptive? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
- 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: ______________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ______________________

Dental History

If you are new to Molinari Dental, **who** and **where** was your previous dentist: ______________________

- Are you having any discomfort at this time? ☐ Yes ☐ No
- How long since your last dental visit? ______________
- Did you have xrays? ☐ Yes ☐ No
- Have you lost any teeth? ☐ Yes ☐ No
If yes, please explain:
- How often do you brush? _______ Floss? _______
When?
- How often do you replace your tooth brush? ________
- Do you use an electric tooth brush? ☐ Yes ☐ No
- Do you snack between meals? ☐ Yes ☐ No

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

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

Emergency Contact Information

In case of an emergency, who should we contact?

Name: ______________________________

☐ Male ☐ Female

Relationship: ______________

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

Employment Information

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

Employer Name: ______________ Occupation: ______________

Address: ______________________________
Street City, State Zip Code Phone

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: ______________

Insurance Information

Primary

Name of Insured: ______________ Insured's Address: ______________
Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Employer Name: ______________

Address: ______________________________
Street City State Zip Code

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

Insurance Plan Name and Address: ______________

Secondary

Name of Insured: ______________ Insured's Address: ______________
Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Employer Name: ______________

Address: ______________________________
Street City State Zip Code

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

Insurance Plan Name and Address: ______________

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. For Medicaid patients; if your insurance deems you not eligible for services you will be billed at our office fee schedule. For services that go over your allowed amount per year under eligible services, you will be billed at Medicaid fee schedule.

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 should this account be turned over to a collection agency, I will be responsible for the collection fees.

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