Patient Information

Patient Name: _____ Today's Date:_____
Last First MI

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

Address: _____
Street Apartment #

_____
City State Zip Code

Phone Home: _____ ___Work: _____Cell:_____

E Mail:_____ Referred by_____

Social Security #: _____ Date of Birth_____

Person Responsible For This Account_____

Do you have Dental Insurance? Yes_____ No_____

Spouse's Name_____ Spouse's Date of Birth_____

Health Information

Physician's name_____ Phone_____

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

☐ 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 you take any medication? Please list_____

- Name of Physician: _____ Phone:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any health problems that are not listed above or 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 doctors at the next appointment without fail.

Signature_____ Date_____

Dental History

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

Are you having any dental problems today?_____

Do you have any difficulty eating?_____

Do you wear dentures?_____ Are they comfortable?_____

Are you happy with the way your teeth look?_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:_____

Have you had any major dental treatment (orthodontics, periodontics, implants, etc.)?_____

Consent for Services

I authorize Dr. Klareich and his staff to perform an examination and to take any X-Rays that are necessary as part of this examination for the purpose of diagnosis and treatment planning.

If necessary for insurance purposes, I authorize release of information acquired in the course of my examination and authorize assignment of benefits directly to the provider

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 made.

In the event that this account is referred for collection, I agree that I will be responsible for all costs of collection including reasonable attorney's fees. Furthermore , in the event that this account is referred to an attorney for collection, I hereby authorize the release of my medical records to said attorney and I authorize that said records be admitted as evidence in any court proceeding.

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