Patient Information

Patient Name: _____ Preferred Name: _____ Gender:____ Date: _____
Last, First MI

Birth Date: _____ Family Status: _____ Social Security #: _____ Drivers License #:_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____

Address: _____
Street Apt # City State Zip Code

Email Address: _____

Employer Name: _____ Occupation:_____

Address: _____
Street City, State Zip Code Phone

Whom may we thank for referring you to our practice?_____

Health Information

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING:_____

Previous Dentist: _____ **Date of Last Visit:** _____ **Reason for this visit:** _____

Have you ever had any of the following? Please check YES or NO:

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Excessive Bleeding	☐	☐	Hypoglycemia	☐	☐	Sinus Problems
☐	☐	Alzheimer's Disease	☐	☐	Excessive Thirst	☐	☐	Jaundice	☐	☐	Stomach Problems
☐	☐	Anemia	☐	☐	Fainting	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	Fever Blisters	☐	☐	Liver Disease	☐	☐	Swelling of Feet / Ankles or Hands
☐	☐	Artificial Joints/Hips	☐	☐	Frequent Cough	☐	☐	Lung Disease	☐	☐	Thyroid Disease
☐	☐	Artificial Heart Valve	☐	☐	Glaucoma	☐	☐	Mental Disorders	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Growths	☐	☐	Mitral Valve Prolapse	☐	☐	Tumors
☐	☐	Blood Disease	☐	☐	Have you ever taken Phen-Phen/Redux?	☐	☐	Nervous Disorders	☐	☐	Ulcers
☐	☐	Blood Transfusion	☐	☐	Hay Fever	☐	☐	Pacemaker	☐	☐	Venereal Disease
☐	☐	Bruise Easily	☐	☐	Head Injuries	☐	☐	Pain in Jaw Joints	☐	☐	X-ray of Cobalt Treatment
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	**Pregnancy** Due date:_____	☐	☐	Yellow Jaundice
☐	☐	Chemotherapy / Radiation	☐	☐	Heart Lesion	☐	☐	Psychiatric Care	☐	☐	Allergy: Penicillin
☐	☐	Chest Pain	☐	☐	Heart Trouble	☐	☐	Radiation Treatment	☐	☐	Allergy: Latex
☐	☐	Cold Sores	☐	☐	Heart Murmur	☐	☐	Recent Weight Loss	☐	☐	Allergy: Sulfa Drugs
☐	☐	Cortisone Medicine	☐	☐	Heart Surgery	☐	☐	Respiratory Problems	☐	☐	Allergy: Ibuprofen
☐	☐	Diabetes	☐	☐	Hemophilia	☐	☐	Rheumatic Fever	☐	☐	Allergy: Tetracycline
☐	☐	Dizziness	☐	☐	Hepatitis A / B	☐	☐	Rheumatism	☐	☐	Allergy: Aspirin
☐	☐	Drug Addiction	☐	☐	Herpes	☐	☐	Scarlet Fever	☐	☐	Allergy: Codeine
☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Shortness of Breath	☐	☐	Allergy: Epinephrine
☐	☐	Epilepsy or Seizures	☐	☐	Low Blood Pressure	☐	☐	Sickle Cell Anemia	☐	☐	Allergies:_____

Office Use: _____

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain: _____
- 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: _____

In case of emergency, whom shall we call: Name _____ **Relationship**_____

Phone Numbers: _____

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, or if my medicines change, I will inform the doctors at the next appointment without fail.

X_____ Date: _____
Signature of patient, parent or guardian

Reviewed by Dr:_____ **Date:**_____ **Reviewed by Dr:**_____ **Date:**_____
Reviewed by Dr:_____ **Date:**_____ **Reviewed by Dr:**_____ **Date:**_____
Reviewed by Dr:_____ **Date:**_____ **Reviewed by Dr:**_____ **Date:**_____

Spouse or Responsible Party Information

Name: _____ Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____

Address: _____

Street Apartment # City State Zip Code

Insurance Information

Primary Insured Persons Information:

Name: _____ Birth Date: _____ ID or SS#: _____

Last First MI

Address: _____

Street City State Zip Code

Employer Name & Address: _____ Group#: _____

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

Insurance Plan Name and Phone Number: _____

Secondary Insured Persons Information:

Name: _____ Birth Date: _____ ID#: _____

Last First MI

Address: _____

Street City State Zip Code

Employer Name & Address: _____ Group#: _____

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

Insurance Plan Name & Phone Number: _____

Consent for Services

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. **However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. Information from your insurance is not a guarantee of payment or eligibility. Insurance will determine benefits when processing claim.**

A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or her staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or her 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

IT IS OUR POLICY TO CHARGE $15.00 PER 15 MINUTES FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS

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.

X_____ **Date:** _____ **Relationship to Patient:** _____

Signature of Responsible Party / Parent or Guardian

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims:

X_____

Signature of Responsible Party/Parent or Guardian

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Juan Andre Gomes, D.D.S.Inc:

X_____

Signature of Responsible Party/Parent or Guardian