

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Date of Birth _____ Gender: _____ Family Status: _____
 Phone (Home): _____ (Work): _____ (Cell): _____
 E-mail: _____
 Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
 Address: _____
Street Apartment #
City Province Postal Code

Health Information

Do you have, or have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Medication Allergies: | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| Penicillin: <input type="checkbox"/> | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| Codeine: <input type="checkbox"/> | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders: | <input type="checkbox"/> Thyroid Disease |
| Other: _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Other Allergies: _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> MS | <input type="checkbox"/> Antidepressant | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | Medication: _____ | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Medication for |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnancy | Osteoporosis: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | Due Date: _____ | _____ |
| | <input type="checkbox"/> Hepatitis: A B C | <input type="checkbox"/> Radiation Treatment | _____ |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems | |

- Are you currently taking any prescription and/or over the counter medications?
Please list any medications, supplements, and or vitamins taken in the last two years:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Do you have a history/or do you currently smoke and/or use tobacco products?

Please list: _____

- 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: _____

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 of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? Internet Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
 Name of person or office referring you to our practice: _____

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 in full 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.

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.

The fee estimate can change during the course of an appointment. We will do our best to inform you of any changes to allow you to make an informed decision on your course of treatment. However, any fee changes that occur are the sole responsibility of the patient.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results.

I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to having dental treatment provided by Copperfield Dental Center.

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)