

Please list any medications you are currently taking and dosages:

- | | |
|----|----|
| 1. | 2. |
| 3. | 4. |
| 5. | 6. |
| 7. | 8. |

Please list any dietary or herbal supplements you are taking, and for what purpose:

- | | |
|----|----|
| 1. | 2. |
| 3. | 4. |
| 5. | 6. |

Women: Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes

Abnormal Blood Pressure? (Please circle)	No	Yes
Have you ever received a diagnosis of "high blood pressure"?		
What is your normal blood pressure? S /D Today: _____ / _____		

Are you allergic or have you had a reaction to:

- | | | |
|---|----|-----|
| a. Local anesthetics | No | Yes |
| b. Penicillin or other antibiotics | No | Yes |
| c. Aspirin, Ibuprofen or Tylenol | No | Yes |
| d. Codeine, Valium® or other sedatives..... | No | Yes |
| e. Latex or Metals | | |
| f. Other (please specify) _____ | | |

Tobacco, Alcohol, Drugs

Do you use tobacco? _____ If yes, circle type: <u>smoke</u> <u>chew</u> How much per day? _____	No	Yes
For how long? _____		
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? _____ If yes, approximately how many alcoholic beverages per week? _____	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies

Sugar in your diet (circle one): *none slight moderate high*

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)

Patient Signature

Date

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Doctor (Print Name)

Doctor Signature

Date

FINANCIAL INFORMATION AND CONSENTS:

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

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: _____

SIGNATURE ON FILE AUTHORIZATION

- I authorize Dr. Barnes to use my name on any claims or documents that relate to Dental Insurance benefits due to me and my dependents.
- I authorize release of any information related to any claims to all my Dental Insurance Companies or other related parties.
- I authorize Dr. Barnes to act as my agent in helping me obtain payment from my Dental Insurance Companies.
- I authorize payment of Dental Benefits otherwise payable to me, directly to Dr. Barnes.
- I permit a copy of this authorization to be used in place of an original.
- Signature on file is valid until I notify Dr. Barnes in writing to cancel.

Signature: _____

Date: _____

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.

****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.

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

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party