ORCHID SPRINGS
DENTAL

Patient Name: _____ Age:_____
(Last) (First) (MI)

Male Female Single Married Minor Other_____

Birth Date: _____ Social Security #: _____

If patient is a minor, parent or guardian's name: _____ Relationship: _____

Preferred name: _____ Email address: _____

Home Address:_____ Home Phone: ( )_____
Cell Phone: ( )_____
City: _____ State: ____ Zipcode: _____ Work Phone:( )_____

Emergency Contact
Name: _____ Relationship to Patient:_____
Home Phone: ( )_____ Work/Cell Phone: ( )_____

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

Responsible Party (person responsible for payment on account)**:** ☐ **Self** **If not Self, please complete below**

Name: _____
Male Female Spouse Mother Father Other _____
Social Security #: _____ Birth Date: _____
Home Phone: ( )_____ Work Phone: ( ) _____
☐ Address same as above
Home Address: _____
City: _____ State:____ Zipcode:_____

Insurance Information

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Name of Insured **Relationship to Pt**	**Name of Insured** **Relationship to Pt**
Birth Date **ID# or SSN**	**Birth Date** **ID# or SSN**
Insured Address	**Insured Address**
City **State** **Zip Code**	**City** **State** **Zip Code**
Insured Employer Name **Group #**	**Insured Employer Name** **Group #**
Insurance Plan Name **Ins Telephone #**	**Insurance Plan Name** **Ins Telephone #**
Effective Date of Plan	**Effective Date of Plan**

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Confidential Health History

Yes No Is your health generally good? If NO, explain _____
_____

Yes No Has there been a change in your health within the last year? If YES, explain _____
_____

Yes No Have you gone to the hospital or emergency room of had a serious illness in the last 3 yrs?
_____

Yes No Have you undergone any major surgeries within the past 3-5 yrs? If YES, please explain/when?_____

If necessary, in the event of needing a **MEDICAL CLEARANCE** for dental treatment, whom may we contact?
Physician Name: _____ Physician's Contact Number _____

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

- ☐ Alcohol/Drug Abuse
- ☐ Asthma
- ☐ Chemotherapy/Radiation
- ☐ Endocarditis/Heart Infection
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Respiratory Disease
- ☐ Hi/Low Blood Pressure
- ☐ Osteoporosis/Osteopenia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Excessive Bleeding
- ☐ HIV+/AIDS
- ☐ Sinus Problems
- ☐ NONE OF THE ABOVE
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Mitral Valve Prolapse
- ☐ Heart Disease
- ☐ Blood Disease
- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ Mental Disorder
- ☐ Prosthetic/Replace Heart Valve
- ☐ Sickle Cell Disease
- ☐ Ulcers/Colitis
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Herpes
- ☐ Shingles
- ☐ Tuberculosis
- ☐ NONE OF THE ABOVE

If there is anything checked above or any conditions not listed that needs further clarification, please explain below.

WOMEN ONLY: Please check all that apply

- ☐ Pregnant (1st Trimester)
- ☐ Pregnant (2nd Trimester)
- ☐ Pregnant (3rd Trimester)
- ☐ Taking Birth Control
- ☐ Nursing
- ☐ Breast Augmentation

Please check any of the following conditions that pertain to your health

- ☐ Latex Allergy
- ☐ Vicodin/Codeine Allergy
- ☐ Penicillin/Amoxicillin Allergy
- ☐ Sensitive to Epinephrine
- ☐ Other Medical Allergies
- ☐ Taking Blood Thinning Medication
- ☐ Taking Fosamax
- ☐ Severe Gag Reflex
- ☐ Anxiety at Dental Appointments
- ☐ Needs Antibiotic Pre-Medication - if checked, why is premed needed _____

If there is anything checked that need further clarification, please explain below.

Medications- Please list any medications you are currently taking.

Name	**Purpose**

Patient/Guardian Signature _____ **Date** _____

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 of services are performed unless other arrangements are made.

Patients with dental insurance understand that while we will bill your insurance for you, you are ultimately responsible for any charges that are not covered. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company in full and estimates of insurance benefits are not a guarantee of payment.

I understand that any fee estimate for this dental care can only be extended for a period of (6) months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for services at the time of treatment, or within (15) days of billing cycle if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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.

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.

Signature of Patient, Parent or Guardian	Date	Relationship to Patient

Reset