Patient Information

First Name:_____ Last Name:_____

Date: _____

Gender: _____ Married _____ Single _____ Birth Date: _____ SSN: _____

E-Mail Address: _____

Address: _____
Street Apt. #

_____
City State Zip Code

Phone #'s: Home _____ Work _____ Ext. _____ Best time to call: _____

Cell _____ Other _____

Occupation/School: _____ Employer/Grade: _____

Who may we thank for referring you to our office? Name: _____ Relationship:_____

Emergency Contact Information

Name: _____ Relationship: _____ Home #: _____

Work #: _____ Cell #: _____

Insurance Information

PRIMARY:

Name of Policy Holder: _____ Birthday: _____

Policy Holders Social Security or ID# _____ Group ID # _____ Union or Local # _____

Insurance Plan Name: _____

Telephone# _____

Policy Holder's Employer Name: _____

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

SECONDARY:

Name of Policy Holder: _____Birthday: _____

Policy Holders Social Security or ID # _____ Group ID # _____ Union or Local # _____

Insurance Plan Name: _____

Telephone # _____

_____

Insured's Employer Name: _____

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

CONSENT FOR TREATMENT

1. I hereby authorize the doctor and designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required in which to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. For women only: I fully understand that using antibiotics reduces the effectiveness of birth control pills and should use other forms of birth control when antibiotics are prescribed.

Client Signature: _____Date _____

Client or Responsible Party (If minor)_____ Relationship_____

MEDICAL HISTORY

1. Have you taken any medication or drugs during the past two years? ..... Yes No
2. Are you taking (or supposed to be taking) any medication, drugs or supplements now? ……..... Yes No

   If so, please list name and dose (please use back of page for more room if needed) _____

   _____

3. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? …….... Yes No

   If yes, please list: _____
4. Have you been a patient in the hospital during the past five years? ……..... Yes No

   If yes, for what procedure(s)? _____
5. Do you have a primary care physician?…….... Yes No

   Name of primary care physician: _____Phone: _____
6. When you walk up stairs or take a walk do you ever have to stop because of chest pain, shortness of breath or tired feeling? ..... Yes No
7. Do you or have you ever smoked tobacco and/or use vape products?..... Yes No

   If yes, quantity/frequency? _____ When did you quit? _____
8. Indicate which of the following you have had, or have at present. **Circle "yes" or "no"** to **each** item.

A.I.D.S. ……	Yes	No	Epilepsy or Seizures……	Yes	No	Kidney Trouble. ……	Yes	No
H.I.V. Positive. ……	Yes	No	Fainting or Dizzy Spells. ……	Yes	No	Latex Sensitivity ……...	Yes	No
Allergies or Hives ……	Yes	No	Glaucoma. ……...	Yes	No	Liver Disease ……	Yes	No
Hay Fever ……	Yes	No	Osteoporosis... ……..…..	Yes	No	Jaundice ……	Yes	No
Sinus Trouble ……..	Yes	No	Hard of Hearing……	Yes	No	Nervous / Anxious ……	Yes	No
Allergy to Local Anesthetic	Yes	No	Head Injury……	Yes	No	Neurological Disorders ……	Yes	No
Alzheimer's……...	Yes	No	Hemophilia/Abnormal Bleeding….	Yes	No	Psychiatric / Psychological Care	Yes	No
Anemia……..	Yes	No	Hepatitis Type_____	Yes	No	Respiratory Problems……..…	Yes	No
Arthritis / Rheumatism ……	Yes	No	History of Drug / Alcohol Abuse….	Yes	No	Emphysema……...	Yes	No
Asthma. ……	Yes	No	Heart (Surgery, Disease, Attack)...	Yes	No	Rheumatic Fever. ……	Yes	No
Blood Transfusion……	Yes	No	High / Low Blood Pressure……..…	Yes	No	Sickle Cell Disease……...	Yes	No
Bruise Easily ……	Yes	No	Heart Murmur……	Yes	No	Stomach Problems……..	Yes	No
Cancer……...	Yes	No	Heart Pacemaker ……	Yes	No	Stroke……	Yes	No
Chemotherapy. ……	Yes	No	Chest Pain ……...	Yes	No	Swollen Ankles. ……	Yes	No
Radiation Therapy……...	Yes	No	Congenital Heart Disease…….	Yes	No	Thyroid Problems. ……	Yes	No
Chronic Cough ……	Yes	No	Mitral Valve Prolapse……	Yes	No	Tuberculosis……..	Yes	No
Cold Sores / Fever Blisters	Yes	No	Artificial Heart Valve……	Yes	No	Tumors……	Yes	No
Cortisone Medicine. ……	Yes	No	Artificial Joints (hip, knee, etc.) ….	Yes	No	Ulcers……..	Yes	No
Diabetes ……...	Yes	No	Premedicate……	Yes	No	Venereal Disease (STD)……...	Yes	No
Diet (Special / Restricted)	Yes	No	Taking Blood Thinner Medication	Yes	No	Taking bisphosphonates……...	Yes	No

9. Do you have or have you had any disease, condition, or problem not listed? …….. Yes No

   If yes, please list: _____

   _____

10. **If applicable:**
    Are you: **Pregnant?** Yes, _____Months No **Nursing?** Yes No **Taking Birth Control?** Yes No

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 any change in my health or medication. (Please sign below)

Patient /Guardian Print Name_____

Patient /Guardian Signature _____ Date_____

Dentist Signature: _____

DENTAL HISTORY

First name:_____ Last Name:_____

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____

Last Full Mouth X-rays _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

Notice of Privacy Practices Acknowledgement

We keep a record of health care services that we provide to you. You may ask to see and/or obtain a copy of that record. You may also ask to make changes to your records. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records or get more information about it by contacting Zachary Cargill, DMD.

Our notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Financial Agreement

All payments are due at the time of service unless other arrangements have been previously made and agreed upon by the treating doctor. Estimation of insurance payment is not a guarantee of coverage. It is the patient's responsibility to pay their balance regardless of insurance coverage. In the event payments are not received by agreed upon dates, a 5 % interest charge may be added to your account. Any payments not received after 90 days of the service date will be sent to a collection agency. Third party financing is available – Please ask the office staff about this if you have questions.

Cancellation Policy

Scheduled appointments are a contract between the doctor and the patient. Any appointments that are canceled with less than 48 hours notice or a failure to arrive for a scheduled appointment may incur a fee of $25 per scheduled hour of time. Patients that need to reschedule their reserved appointment time will need to call during **OFFICE HOURS ONLY**. If a message is left during weekends or times when the office is not open, it will not be considered acceptable advanced notice. But, please still leave a message to inform us so that we may take you off the schedule.

If you have any questions we want to hear from you. We look forward to being of service to you.
By my signature below I acknowledge receipt and agree to the Notice of Privacy Practices and Office Policies.

Patient or legally authorized individual signature Date

Printed name Relationship to the patient (If not self)