

PATIENT INFORMATION

Patient Last Name: _____ First name _____ MI _____

Address: _____
Street Apt # City State Zip

Preferred Name: _____ Spouse's Name: _____ Male Female Date of Birth: ____/____/____

Home Phone: _____ Work: _____ Cell: _____

Marital Status: Single Married Divorced Widowed Social Security #: _____

Email address: _____ Best place to contact you? Home Cell Work Email

Employer's name: _____ Occupation: _____
(Please check employment status: Full Part Time)

School Name: _____ Student ID (if you have dental insurance): _____
(Please check student status: Full Part Time)

Emergency Contact: _____ Emergency phone(s): _____

HEALTH INFORMATION

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

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS, HIV Positive | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | Due Date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis (Type _____) | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Allergies to other Medications |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stomach Problems | |

Medications currently being taken: _____

Empty rectangular box with a blue border.

MEDICAL ALERT
(PLEASE DO NOT WRITE IN THIS SPACE)

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past 2 years? Yes No

If yes, please explain: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another patient, friend, or relative Another dental office

Website Newspaper School Work Email Other: _____

Name of person or office referring you to our practice: _____

Individual Responsible for payment of your account (Only complete if different from patient information):

Guarantor's Last Name: _____ First name _____ MI _____

Address: _____
Street Apt # City State Zip

Marital Status: Single Married Widowed Social Security #: _____

Date of Birth: ____/____/____ Preferred Email address: _____

Employer's name: _____ Relationship to patient: _____

-----DENTAL INSURANCE INFORMATION-----

Section A (only complete if policy is not in your name):

Policy Holder's Name: _____
Last First MI

Address: _____
Street Apt # City State Zip

Is policy holder a patient of our practice? Yes No

Policy holder's date of birth: _____ Policy holder's social security #: _____

Policy holder's employer: _____

Home Phone: _____ Work: _____ Cell: _____

Section B (only complete if you did not give us a current dental insurance card):

Insurance company name: _____

Ins. Co. claim mailing address: _____
Street or PO Box City State Zip

Ins. Co. phone # for eligibility: _____ Ins. Co. Phone # for Claims: _____

Group ID: _____ Policy #: _____ Other #: _____

-----CONSENT FOR DENTAL SERVICES-----

Please read and sign:

I agree to pay the amount charged for all services rendered by this office at the time of treatment. If I fail to remit payment for services rendered, I agree to pay all costs and reasonable attorney fees incurred by this office to collect my balance.

Patients who carry dental insurance understand that you are personally responsible for payment of all dental services rendered by Dr. Chamberlin or his assignees. Dr. Chamberlin's office will help prepare your insurance forms and assist in making collections from insurance companies based on the information provided on this form. Any such collections from insurance will be credited to your account. However, this office cannot guarantee what your insurance company will pay for your treatment. I understand that I am ultimately responsible for payment in full of all services rendered by this office.

I grant permission to Dr. Chamberlin, or his assignees, to telephone me at home, work, cell phone number, or by email to discuss any matters related to my dental treatment; the associated fees due for services rendered; or any other matter related to information on this form. I understand that any photos or video taken by Dr. Chamberlin and/or staff are the property of Dr. Chamberlin. However, photos or videos taken by Dr. Chamberlin and/or staff may not be used for external marking without my signed consent.

If I ever have any change in my health, I will inform Dr. Chamberlin or his assignees at the next appointment without fail.

To the best of my knowledge, all of the proceeding answers and information provided are true and correct.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian: _____ Date signed: _____

Relationship to patient: _____

