WELCOME

Patient Information

Patient Name____ Date_____________
Last Name First Name MI (Preferred Name)

Address__________________________City_______________ State _________ Zip_________

Sex Male Female Birth Date _________________ Social Security # _______________

Married Widowed Single Minor/Child Divorced Email___________________

If Married: Spouse's Name__________________ Birth Date___________ SS#_____________

Spouse's Employer ________________ ___Spouse's Work Phone Number__________________

Phone Numbers

Home_____________________Work_________________Ext_______ Cell_________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _______________________________________Relationship _________________________

Home Phone ______________________________ Work Phone ____________________________

Employment Information

Occupation______________________________ Employer_______________________________

Employer Address__________________________ Employer Phone Number_________________

Health History

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

AIDS
Allergies_______
____
Anemia
Arthritis
Artificial Joints
Date placed______
____
Asthma
Inhaler Y N
Blood Disease
Cancer

Codeine Allergy
Diabetes
Dizziness
Excessive Bleeding
Fainting
Glaucoma
Growths
Hay Fever
Heart Disease/Condition
Head Injuries
Heart Murmur
Hepatitis

High Blood Pressure
Iodine Allergy
Jaundice
Kidney Disease
Liver Disease
Mental Disorders
Nervous Disorders
Pacemaker
Penicillin Allergy
Pregnancy
Due Date___________
Radiation Treatment

Respiratory Problems
Rheumatic Fever
Sinus Problems
Stomach Problems
STD
Stroke
Tuberculosis
Tumors
Ulcers
Other:
____
____

Health History Continued

Have you ever had any complications following dental treatment? Yes No
If yes, Please explain: ____________________

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: ____________________

Have you recently been diagnosed, treated, or exposed to infections or M.R.S.A?
If yes, Please explain: ____________________

Do you have any health problems that need further clarification? Yes No
If yes, Please explain: ____________________

List any **prescription medications** you are taking:

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

Consent for Services

All emergency dental services, or any dental services without previous financial arrangements, must be paid for in cash at the time services are performed. A service charge of 18% on the unpaid balance will be charged on all accounts exceeding 90 days.

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 patients account. **However, this dental office cannot provide services on the assumption that our charges will be paid by an insurance company**.

You are hereby notified if collection procedures become necessary, you may be reponsible for attorney fees incurred with regard to the collection of your past due account.

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.

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 disclosed any health problems or concerns that I have and all medications that I am taking prior to signing this form.

I understand that there are certain inherent and potential risks with any procedures, the most common operative risks include, but are not limited to pain, infection, swelling, bleeding, bruising and dry socket. There can be pain, numbness or inflammation anesthetic from injection of anesthetic. In addition I understand I could experience racing of the heart and/or shortness of breath temporarily if anesthetic inadvertantely enters vein or artery. If trauma/damage to the nerve occurs this could include, but is not limited to numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness which could occur, may be a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be a result of surgical procedures or anesthetic administration. By signing this form, I am giving my consent to allow and authorize Dr J. Alan Timmons and his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

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