

# Personal Information

Today's Date: \_\_\_/\_\_\_/\_\_\_

## Patient Information

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_  
Last First MI (Preferred Name) Sex:  Male  Female  
Status:  Married  Single  Child

Social Security # \_\_\_ - \_\_\_ - \_\_\_ Drivers License # \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address \_\_\_\_\_  
Street Apartment # City State Zip Code

Mailing \_\_\_\_\_  
(if different) Street Apartment # City State Zip Code

Phone #'s: Home (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Best times and phone # to call: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address \_\_\_\_\_  
Street Suite # City State Zip Code

Are you the Responsible Party (guarantor of payment) for this account?  Yes If yes, continue on other side.  
 No If no, fill out the information directly below.

## Responsible Party Information

Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_  
Last First MI (Preferred Name) Sex:  Male  Female  
Status:  Married  Single  Child

Social Security # \_\_\_ - \_\_\_ - \_\_\_ Drivers License # \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address \_\_\_\_\_  
Street Apartment # City State Zip Code

Mailing Address: \_\_\_\_\_  
(if different than above) Street Apartment # City State Zip Code

Phone #'s: Home (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_  
Fax (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Best times and phone # to call: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address \_\_\_\_\_  
Street Suite # City State Zip Code

See Other Side

## Referral Information

Who may we personally thank?

Patient       Family Member       Doctor       Other

▶ Name: \_\_\_\_\_

Or did you hear about us from another source?

Location      Radio:  KSLR     KLUP

Web Site       Other: \_\_\_\_\_

## CONSENT FOR SERVICES

**All dental treatment must be paid for at the time services are performed. We provide several methods for payment: cash, check, Visa, Master Card, Discover, American Express and outside financing.**

**I grant permission for Dental Solutions to use photographs for documentation and training purposes.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## Emergency Information

If an emergency occurs, who should we contact? \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
NAME PHONE RELATIONSHIP

Additional contact (nearest relative not living with you) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
NAME PHONE RELATIONSHIP

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

**yes    no**

Do you have active Tuberculosis?    

Do you have a cough that produces blood?    

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?    

If yes, what antibiotic and dose? \_\_\_\_\_ / \_\_\_\_\_

Name of physician or dentist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?    

If yes, when was this operation done? \_\_\_\_\_

Have you had any complications or difficulties with your prosthetic joint?    

**NOTE TO PATIENT:** A report from July 1997, prepared and endorsed by the American Dental Association and the American Academy of Orthopedic Surgeons has recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints. This office will be glad to discuss this report with you and provide a copy to you and your orthopedic surgeon/physician.

## Insurance Information

Do you have dental insurance?     No     Yes

If yes, please complete the "INSURANCE INFORMATION"