Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I understand that this examination is going to address my immediate problem or emergency and should not be confirmed as a complete examination with resulting treatment.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist of dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by dental or medical care payor.

FINANCE CHARGE. If I don't pay the entire New Balance within 25 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $134) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

Medical Information

Name of Your Physician _____ Last Physical _____

Are You Taking Any Medications? _____ Please List _____

_____

_____

Are You Allergic To Any Medications/Food? _____ Please List _____

_____

Have You Been Hospitalized In The Last 5 Years? _____ Why? _____

_____

Do You Have, Or Have You Ever Had?	Please Circle	
Heart Murmur	YES	NO
Fainting Spells	YES	NO
Heart Condition	YES	NO
Malignancy	YES	NO
Abnormal Blood Pressure	YES	NO
Tuberculosis	YES	NO
Abnormal Bleeding	YES	NO
Positive HIV Test	YES	NO
Anemia	YES	NO
Radiation Therapy	YES	NO
Diabetes	YES	NO
Venereal Disease	YES	NO
Epilepsy/Seizure	YES	NO
Hepatitis	YES	NO
Asthma	YES	NO
Rheumatic Fever	YES	NO
Might You Be Pregnant?	YES	NO

Dental Information

How Long Has It Been Since Your Last Dental Visit? _____

What Was Done At That Time? _____

_____

What Is Your Problem or Complaint At This Time? _____

_____

_____

How Long Has It Been A Problem? _____

Comments _____

_____

_____

Medical Updates -- Dental and Medical Histories -- Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past & present conditions.

DATE	EXCEPTIONS		PATIENTS SIGNATURE	B.P.	REVIEWED BY
_____	_____	NONE ❑	_____	_____	DR. _____
_____	_____	NONE ❑	_____	_____	DR. _____
_____	_____	NONE ❑	_____	_____	DR. _____
_____	_____	NONE ❑	_____	_____	DR. _____
_____	_____	NONE ❑	_____	_____	DR. _____
_____	_____	NONE ❑	_____	_____	DR. _____
_____	_____	NONE ❑	_____	_____	DR. _____