Welcome

New Patient information

First Name: _____MI_____Last_____
Today's date _____ Male Female Birthdate_____
Address _____ City_____ St_____ Zip_____
Social Security No. _____ phone_____

Responsible Party Information

First name: _____MI____Last_____
Home phone _____ cell _____ work _____
Social Security No._____ Birthdate _____
E-mail _____ Driver's license no. _____
Employer _____ Occupation _____
Spouse's name _____ Spouse's employer _____
Whom may we thank for referring you? _____
Person to contact in case of emergency?
Name _____ Relationship _____
City _____ St _____ phone _____

Agreement to Pay

I hereby agree to pay my account, as services are rendered, i.e. co-payment, deductible, or percentage not covered by my insurance. If for any reason a balance is owing on my account, I agree to pay that upon receipt of the statement. I (we) understand that responsibility for the payment for services provided in this office is mine (ours) due and payable at the time of service regardless of any insurance. I (we) further understand that negative balances will be sent to collections and in the event of collections I agree to pay 18% interest from the date of service, reasonable attorney fees, and court costs incurred. I authorize release of any information, including diagnosis, records of treatment or examination rendered to my insurance company. A missed appointment fee of $25.00 maybe charged without 24 hours cancellation notice.

Signature _____ Date _____
Relationship if patient is under 18 years of age _____

New Patient Dental History

Reason for today's visit _____
Are you in pain? Y N If so please describe _____
Do you have any dental problems now? _____
Have you ever had trouble with previous dental treatment? _____

Have you ever had?

Periodontal disease/gum disease	Y	N	Discomfort in your jaw joint (TMJ/TMD)	Y	N
Orthodontics	Y	N	Serious injury to mouth or head	Y	N
Oral surgery	Y	N	**If yes to any questions describe below:**		

New Patient Medical History

Please circle any of the following that you are **allergic** to or have had **adverse reaction** to:

Aspirin	Iodine	Sedatives
Codeine	Jewelry/Metals	Sulfa Drugs
Anesthetics (Novicaine)	Latex	Tetracycline
Erythromycin	Penicillin or other antibiotics	

Other_____

Have you been hospitalized or under the care of a medical doctor during the past 2 years? Y N

If so for what? _____

Physician's name _____ Phone _____

Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? Y N

Are you currently taking any medications or drugs? (Including over the counter meds) Y N

Please list and explain _____

_____

Do you have heart problems? Y N _____

Are you pregnant? Y N Are you taking birth control pills? Y N

Circle the following you have had or have at present:

AIDS/HIV	Eating disorder	Mitral Valve Prolapse
Alcohol addiction	Difficulty breathing	Nervousness/anxiety
Allergies or hives	Emphysema	Neurological disorders
Anemia	Epilepsy or Seizure	Osteoarthritis
Arthritis/rheumatism	Fainting or dizzy spells	Psychiatric Care
Artificial heart valve	Fosamax	Radiation therapy
Joint replacement	Glaucoma	Rheumatic/scarlet fever
Asthma	Hay Fever	Shingles/chicken pox
Bisphosphonate Drugs	Heart (surgery, disease)	Sinus trouble
Blood disease	Heart Pacemaker	Snoring/sleep apnea
Blood transfusion	Heart Murmur	Stroke
Boniva	Hemophilia	Tobacco use
Bruise easily	High blood pressure	Thyroid problems
Cancer/chemotherapy	Low blood pressure	Tuberculosis (TB)
Chest pain	Hepatitis A, B, or C	Tumors
Cold sores/herpes	Hospitalized	Venereal disease/STD
Colitis	Kidney trouble	
Cortisone medicine	Liver disease	
Diabetes	Lupus	

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 healthcare provider or agency that may release such information to our office. I will notify the dentist of any changes in my health or medication.

Signature _____ date _____

Acknowledgement of receipt of notice of privacy practices of Mary Ellen Argus, D.D.S.

I acknowledge that I have read and or received a copy of the Notice of Privacy Practices. This notice describes how the practice of Mary Ellen Argus, D.D.S. may use and disclose my healthcare information, and rights I may have regarding my protected health information.
Signature _____ date _____