



Today's Date \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
Last First MI Preferred

Gender:  Male  Female      Status:  Married  Single  Child  Other

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_      SSN# \_\_\_\_\_      Email: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City St Zip Code

Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Mobile Work Other

**Spouse or Guardian Information** (if applicable)

Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      SSN: \_\_\_\_\_      Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City St Zip Code

Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ ext: \_\_\_\_\_

**Primary Dental Insurance Information**

Insurance Company: \_\_\_\_\_ Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City St Zip Code

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Member ID # \_\_\_\_\_      SSN \_\_\_\_\_

Patient's Relationship to Insured:  Self  Spouse  Child  Other

Address: \_\_\_\_\_  
of insured Street City St Zip Code

Name of person filling out this form: \_\_\_\_\_  
Printed Name Signature

Relationship to patient:  Self  Other (describe): \_\_\_\_\_



Medical History

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Are you allergic to any of the following? Aspirin, Penicillin, Codeine, Acrylic, Metal, Latex, Local Anesthetics, Sulfa Drugs, Other

- Do you have, or have you had, any of the following? AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problem, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, High Cholesterol, Heart Attack/Failure, Heart Murmur, Heart Pace Maker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.



**Financially Responsible Party**  Check if this information is different from the insured

Name: \_\_\_\_\_  
Last First MI

Gender:  Male  Female Status:  Married  Single  Child  Other

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ ext: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City St Zip Code

**Employment Information**

The following is for the person responsible for payment

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City St Zip Code

**Consent for Services & Financial Policy**

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient will be determined before treatment, and that amount is due at the time of treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance agree that it is the patient's personal responsibility to pay for all dental services rendered. As a matter of convenience to the patient, the dental office will prepare and submit the necessary insurance forms and use reasonable efforts to collect from the patient's dental insurance carrier the benefits which are extended to the patient. All credits received will be applied to the patient's account. However, the patient understands and agrees that the dental office cannot do more than submit insurance claim forms and credit any payments received. The contract of insurance is between the patient and the patient's dental insurance company. If the dental insurance company pays nothing, or pays less than what the patient anticipated, the patient understands and agrees that it is the patient's responsibility to pay the balance owed. Further, the patient understands and agrees that any estimate of any benefit that may be paid by the patient's dental insurance company is purely an estimate and that the amount of any credit that will be ultimately applied will be the actual amount paid. Treatment estimates are based on applicable contracted insurance fee schedules. When insurance payment is denied due to plan limitations or exclusions, or when coverage is terminated, these denied charges will revert to Sean Sinclair Family Dentistry's Usual and Customary Fees, and the patient is responsible for all applicable costs incurred. It is the patient's responsibility to keep scheduled appointments. Failure to show for an appointment or to notify Sean Sinclair Family Dentistry of a cancelled appointment within 24 hours of the time allotted may incur a cancellation charge.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable legal & collection fees.

I have read and fully understand the conditions of treatment and my personal financial responsibility and by signing herein below agree to those terms. In the event that I am not the patient, I agree to said terms on behalf of the patient as the patient's parent or legal guardian.

Signature of patient, parent or guardian (Responsible Party): \_\_\_\_\_

Printed Name of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Patient's Name: \_\_\_\_\_



**Authorization & HIPAA Release**

I hereby certify that I have read and understand the previous information, and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate.

I authorize Sean Sinclair Family Dentistry to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent or legal guardian: \_\_\_\_\_  
Signature

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

List of additional names we can release information to:
