Armstrong DENTAL

Patient Information

Patient Name: _____ Date: _____

Social Security # _____ Birth Date: _____ Family Status: _____

Phone: (Home) _____ (Work) _____ (Cell) _____ (Daytime) _____

E-Mail _____ Best Way to Contact you: Phone, E-Mail, Text_____

Address: _____

City: _____ State: _____ Zip Code: _____

Health Information

Date of Last Dental Visit: _____ Reason for this Visit: _____

Have you had any of the following – Please check those that apply

_____ Aids	_____ Excessive Bleeding	_____ Liver Disease	_____ Stroke
_____ Allergies	_____ Fainting	_____ Mental Disorders	_____ Tuberculosis
_____ Anemia	_____ Glaucoma	_____ Nervous Disorders	_____ Tumors
_____ Arthritis	_____ Growths	_____ Pacemaker	_____ Ulcers
_____ Artificial Joints	_____ Hay Fever	_____ Pregnancy– Due Date:_____	_____ Venereal Disease
_____ Asthma	_____ Heart Disease	_____ Radiation Treatment	_____ Blood Disease
_____ Heart Murmur	_____ Respiratory Problem	_____ Cancer	_____ Diabetes
_____ High Blood Pressure	_____ Rheumatism	_____ Dizziness	_____ Jaundice
_____ Sinus Problems	_____ Epilepsy	_____ Kidney Disease	_____ Stomach Problems

☐ Have you ever had any complication following dental treatment? _____Yes _____No
If Yes, Please explain: _____

☐ Have you been admitted to a hospital or needed emergency treatment during the past two years? If yes, Please explain:
_____

☐ Are you now under the care of a physician? If yes, Please explain
_____

☐ Physician name: _____ Physician Phone # _____

☐ Do you have any health issues that need further clarification:
_____
_____

☐ Are you taking any medications? If yes, please list the medications you are taking:
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Responsible Party Information

The following is for the person responsible for payment

Name: _____ Birth Date: _____

SS#: _____ Phone (Home) _____ (Work) _____ (Cell) _____

Address: _____

Employment Information

The following is for the patient_____ Person responsible for payment _____

Employer Name: _____ Occupation: _____

Insurance Information

Primary Insurance:
Name of Insured: _____ Is Insured a patient Yes____ No ____

Insured's Birth Date: _____ ID# _____ Group # _____

Insured's Address: _____

Insured's Employer Name: _____
Patient's relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Insurance Plan Name and Address: _____

_____

Secondary Insurance:
Name of Insured: _____ Is Insured a patient Yes____ No ____

Insured's Birth Date: _____ ID# _____ Group # _____

Insured's Address: _____

Insured's Employer Name: _____

Patient's relationship to Insured: Self _____ Spouse _____ Child _____ Other _____
Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before 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.

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 patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 attorney fees if suit be instituted hereunder.

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 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

Release for Use of Images

I hereby give my consent to Armstrong Dental to photograph and then use, reproduce, and publish said images of me and/or my child/children.

_____
(Please print name)

_____
(Please print child's name)

I agree that photographs/negatives thereof shall constitute the sole property of Armstrong Dental, with full right of disposition in any manner whatsoever, including the right to publish on their website damonarmstrongdds.com.
I hereby release Armstrong Dental and his/her legal representatives and assigns from any and all claims whatsoever in connection with the use, reproduction, publication of the images thereof.

_____ Date: _____
Signature

_____ Date: _____
Signature for minor child

_____
Address Phone: