PATIENT INFORMATION
NORTH END DENTAL P.L.L.C.

Patient Name: _____ (_____) Date: _____
Last, First MI (Preferred Name)

Gender: ____ Birth Date:_____ Age: _____ SS #: _____ DL# _____

Phone (Home): _____ (Work): _____ Ext: _____ E-mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

REASON FOR THIS APPOINTMENT : _____

Do you have or have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints or Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Currently **Pregnant** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

CURRENT MEDICATIONS:

_____

APPROXIMATE DATE OF LAST DENTAL VISIT:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

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

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

(OVER)

Responsible Party Information

The following is for the person responsible for payment

Name: _____

☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Employer: _____ Phone (work):_____ Phone(home): _____

Billing Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information

Name of Subscriber: _____
Last First MI

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

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

DENTAL INSURANCE PLAN NAME_____

DENTAL INSURANCE BILLING ADDRESS_____

INSURANCE CUSTOMER SUPPORT PHONE NUMBER_____

Consent for Services/Office Policy

I give permission for my dentist and his/her clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and 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.

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance coverage.

I assign dental benefit payments to be paid directly to North End Dental P.L.L.C. from my insurance company.

I understand that I may incur an 18% per annum finance charge if my balance goes beyond 60 days.

I understand that any fee estimate given for 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 by the Doctor or his/her clinical team, 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.

I understand that North End Dental PLLC reserves the right to discontinue treatment if I fail to keep an appointment without 24 hour prior notification.

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor, patient, parent or guardian(if minor)