

FINANCIAL AGREEMENT

- * For my convenience, this office may release my information to my insurance, and receive payment directly from them.
- * If sent to collections, I agree to pay a **\$30 collection fee**, all related fees and court costs.
- * Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- * Treatment plans may change, and I will be responsible for the work actually done.

Signature _____ Date _____

MEDICAL HISTORY

Name of Medical Doctor: _____ City/State _____

Emergency Contact _____ Phone _____ Relationship _____

List all the medications or drugs you are now taking:

[] None

Check medications or drugs you are allergic to:

- None
- Aspirin
- Codeine/ Other Narcotics
- Erythromycin
- Latex Rubber
- Local Anesthetics
- Metals
- Penicillin
- Sulfa Drugs
- Other: _____

Check any medical conditions you may have:

- None
- AIDS/HIV
- Alcohol/Drug Abuse
- Anemia/Leukemia
- Anorexia/Bulimia
- Arthritis
- Asthma/Hay Fever
- Blood Clotting Problems
- Blood Transfusion
- Bronchitis
- Cancer/Tumor or Growth
- Cardiac Pacemaker
- Chest Pain Upon Exertion
- Damage Heart Valve
- Other: _____
- Diabetes
- Emphysema
- Epilepsy
- Fainting Spells/Seizures
- Fever Blisters/Herpes
- Frequent Headaches
- Frequently Dry Mouth/Sjogren
- Gall Bladder Trouble
- Heart Attack/Stroke
- Heart Disease/Angina
- Heart Murmur
- Hepatitis/Jaundice
- High Blood Pressure
- Hives/Skin Rash
- Joint Replacement, Date of: _____
- Kidney/Bladder Trouble
- Liver Disease
- Low Blood Pressure
- Mental Health Problems
- Mitral Valve Prolapse
- Persistent Diarrhea
- Rheumatic Fever
- Rheumatic Heart Disease
- Sexually Transmitted Disease
- Sinus Trouble
- Stomach Ulcers
- Thyroid Problems
- Tuberculosis

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? Yes / No

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? Yes / No

New patients:

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Name (printed)

Date

Patient/Guardian Signature