## Patient Information

Patient Name: ______________________________________________ Date:______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________________ Birth Date:________________________

Phone (Home): ______________ (Work): ______________ Ext:_____ (Cell phone):____________

E-mail address:____________________ **How would you prefer to confirm appointments: Phone – text – E-mail**

Address: ______________________________________________________
Street Apartment #

______________________________________________________
City State Zip Code

## Health Information

Date of Last Dental Visit: ______ Previous Dentist_____________ Reason for visit today:________________

**Have you ever had any of the following? Please check those that apply:**

☐ AIDS/HIV
☐ Allergies __________
__________
☐ Sinus Problems
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma

☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Ulcers
☐ Hepatitis A B C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis
☐ Pacemaker
☐ Tuberculosis

☐ Stroke
☐ Radiation Treatment
☐ Respiratory Problems
☐ Venereal Disease
☐ Tumors
☐ Stomach Problems
☐ ***Rheumatic Fever***
☐ ***Pregnancy:***
Due date:__________
☐ ***Diet Pills***
☐ ***Weight Loss Surgery***
☐ ***Artificial Joints***
☐ ***Heart Murmur***
☐ ***Mitral Valve Prolapse***
☐ ***Codeine Allergy***

☐ ***Penicillin Allergy***
☐ ***Sulfa Allergy***

☐ ***Current Medications***
__________________
__________________
__________________
__________________
__________________
__________________

☐ ***Other conditions***__________
__________________
__________________

- 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:________________

*Are you currently taking **bisphosphonate's** for osteoproosis, breast cancer, prostate cancer, or multiple myeloma?____________________________________________________________

* **If female**, are you taking birth control pills?______ *If yes, antibiotic therapy may render your birth control ineffective.*

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

***There is a $25.00 charge for missed or cancelled appointments without a 24 hour advance notice. After 3 appointments missed or cancelled without a 24 hour advance notice we will no longer be able to see you as a patient.***

## 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:________________________________________

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ______________

Address: ______________________________

Street Apartment #

______________________________

City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________

Street City State Zip Code

## Insurance Information

**Primary**

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

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

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

______________________________

**Secondary**

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

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

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

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. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for 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. A $30 service charge will be added to all accounts that have a check returned for insufficient funds.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

I authorize Dr. LaMartina and/or Dr. McMann and his staff to perform diagnostic services and treatment as may be necessary for dental care of myself or my dependents.

I authorize the release of any information regarding my health history, treatment, or proposed treatment, by Westmount Dental Arts to another dentist or insurance company.

I hereby assign all insurance benefits for which I am entitled, including private insurance and any other dental plan to Dr. LaMartina.

In consideration for the professional services rendered to me, by the doctor, I agree to pay therefore the reasonable value in full of said services to Westmount Dental Arts, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I agree to pay the actual cost of collections including any court costs and attorney fees if suit is initiated or a collection ageny be utilized.

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 agree to their content.

______________________________ Date: ______________ Relationship to Patient: ______________

Signature of patient, parent or guardian * ***This will serve as the responsible party's signature on file for the purpose of administering insurance benefits.***