GALVAN DENTAL CARE

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Driver License: _____

Prefer Phone: _____ Other #: _____ E-mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact: _____
Name Number

Physician Name & Number: _____ Medical Record # _____

Health Information

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

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

YES NO	YES NO	YES NO	YES NO
☐ ☐ AIDS	☐ ☐ Glaucoma	☐ ☐ Pregnancy	☐ ☐ Codeine Allergy
☐ ☐ Allergies - Latex	☐ ☐ Growths	Due date: _____	☐ ☐ Penicillin Allergy
☐ ☐ - Bisphosphonate	☐ ☐ Hay Fever	☐ ☐ Radiation Treatment	
☐ ☐ Anemia	☐ ☐ Head Injuries	☐ ☐ Respiratory Problems	OTHER: Allergies to Medications (indicate)
☐ ☐ Arthritis	☐ ☐ Heart Disease	☐ ☐ Rheumatic Fever	☐ _____
☐ ☐ Artificial Joints	☐ ☐ Heart Murmur	☐ ☐ Rheumatism	
☐ ☐ Asthma	☐ ☐ Hepatitis	☐ ☐ Sinus Problems	☐ _____
☐ ☐ Blood Disease	☐ ☐ High Blood Pressure	☐ ☐ Stomach Problems	
☐ ☐ Cancer	☐ ☐ Jaundice	☐ ☐ Stroke	Blood Pressure: _____
☐ ☐ Diabetes	☐ ☐ Kidney Disease	☐ ☐ Tuberculosis	
☐ ☐ Dizziness	☐ ☐ Liver Disease	☐ ☐ Tumors	
☐ ☐ Epilepsy	☐ ☐ Mental Disorders	☐ ☐ Ulcers	
☐ ☐ Excessive Bleeding	☐ ☐ Nervous Disorders	☐ ☐ Venereal Disease	
☐ ☐ Fainting	☐ ☐ Pacemaker		

- 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 being treated for any medical condition at the moment? ☐ Yes ☐ No
  If yes, please explain: _____
- List all medical surgeries you had in the past: _____
- List all medications you are taking: _____
  _____
- 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.

Patient/Parent Signature _____ Date: _____

Doctor Signature _____ Date: _____

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 _____

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. 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.

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.

We are currently using unencrypted email. Do we have your permission to send you e-mails regarding your treatment, financial, or insurance information? YES / NO

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/responsible party

_____ Date: _____
Doctors Signature