



**Patient Information**

Email Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)

Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

**Health Information**

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Sinus Problems     |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Stomach Problems   |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Mental Disorders      | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Other Allergy      |
| <input type="checkbox"/> Fainting           | <input type="checkbox"/> Pregnancy             | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Glaucoma           | Due date: _____                                | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Growths            | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Hay Fever          | <input type="checkbox"/> Respiratory Problems  | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Head Injuries      | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Heart Murmur       |  | <input type="checkbox"/> _____              |

Medications/ indicated for...

• 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: \_\_\_\_\_

### 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: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

### Dental 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: \_\_\_\_\_

### CONSENT FOR SERVICES

I authorize Dr. John J. Schinto, III to render medical treatment to me or to the person on whose behalf I have legally signed.

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.

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 90 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 90 days 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.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_