

Medical History

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

Vascular

Heart Disease

Please Describe: _____

Heart Attack(s)

Describe: _____

Heart Rhythm

Problems

Describe: _____

High Blood Pressure

Stroke

Low Blood Pressure

Heart Murmur

Anurisms

Describe: _____

Rheumatic Heart

Fever

Mitral Valve Prolapse

Artificial Joints

Type(s): _____

Anemia

Blood Diseases

AIDS

Hepatitis

Hepatitis B

Hepatitis C

Hepatitis D

Other: _____

Asthma

Diabetes

Type: _____

Dizziness

Epilepsy

Excessive Bleeding

Following Any Surgery

or Injury

Fainting

Glaucoma

Growths

Hay Fever

Head Injuries

Jaundice

Kidney Disease

Liver Disease

Mental Disorders

Nervous Disorders

Pacemaker

Pregnancy

Due date: _____

Radiation Treatment

Respiratory Problems

Rheumatic Fever

Rheumatism

Sinus Problems

Stomach Problems

Stroke

Tuberculosis

Tumors

Mouth or Lip Ulcers

How Often Do You Get

Them: _____

Are You Using Anything

To Treat Them: _____

What Are You

Using: _____

Venereal Disease

Allergies/ Bad

Reactions to :

Penicillin

Erythromycin

Cephalexin (Keflex)

Clindomycin

Aspirin

NSAIDS – Non-

Steroidal Anti

Inflammatory Drugs

Codine products

Other: _____

• Please List ALL Drugs and Medications You Are Taking (Both Prescription and Non- Prescription Drugs):

Have You Ever Been Treated For Cancer? If Yes, Please Elaborate: _____

• 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(s): _____ Phone: _____

_____ 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 Internet School Work Other _____

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

Spouse or Responsible Party Information

To Be Filled Out if Different from You

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: _____ Cell Phone: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

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

Employer Name: _____ Position: _____

Address: _____
Street City State Zip Code Phone

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.

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.

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.

Photographs: I agree to allowing Lee Fitzgerald, DDS, PA and their agents to use the photographs of any portion of my dental treatment for the purpose of teaching, in publications related to dentistry, and any marketing or advertising media including but not to the internet.

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: _____