Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____Family Status: Married, Single, Child, Widow, Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

E-MAIL:_____ **Payment Method**:(circle) Cash, Check, Credit Card

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:

- ☐ Please List Allergies _____ _____
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Chest Pain /Pressure
- ☐ Hepatitis type:
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancies Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Tobacco Use
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ AIDS
- ☐ Sickle Cell Trait
- ☐ Thyroid disease
- ☐ Have you taken bisphosphonate (fosamax, boniva, actonel)

LIST CURRENT MEDS:
☐ _____ _____ _____

• Have you ever had : Bleeding gums_____Breath Problems_____Chewing Difficulty_____

Night Grinding____Do you use gum____Eat Candy____Drink Sodas____Take Vitamins_____Eat Fruits/Veg_____

Type of toothbrushused(electric/hand)_____Bristles(hard/soft)_____Floss_____

Use irrigating device_____Use Floride Toothpaste_____

Have you had X-RAYS: Medical_____Dental_____Radiation Therapy_____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain_____Date of Last **Medical** Exam:_____

• Name of your Medical 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: _____

Responsible Party Information

The following is for: ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ 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 Phone

Insurance Information

Primary

Name of Subscriber: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____ ID/SS #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

_____

Secondary

Name of Subscriber: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Subscriber'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 Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

_____

Consent for Services/Financial Policy

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. Payment is expected at the time of service rendered.

All **emergency** dental services 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. **Insurance estimated co-payments/deductibles are due at time of service**. Please remember, insurance does not always cover all of your dental expenses. You are responsible for knowing your insurance policy coverage and exclusions.

In the event of default of payment due to Guy G. Levy, DDS, PC, I agree to pay all costs of collection including a 33 1/3% attorney's fee. I authorize the use of a photocopy of my signature.

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.

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. I have been given access to the Notice of Privacy Practices.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian, guarantor of payment