

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:

- | | | | |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Please List Allergies

_____ | <input type="checkbox"/> Fainting
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Growths
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Chest Pain /Pressure
<input type="checkbox"/> Hepatitis type:
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Pregnancies
Due date: _____
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors
<input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> AIDS
<input type="checkbox"/> Sickle Cell Trait
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Have you taken
bisphosphonate
(fosamax,
boniva, actonel)
LIST CURRENT MEDS:
<input type="checkbox"/> _____

_____ |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

• 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 toothbrush used (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.

Signature of patient, parent or guardian 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 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