Patient Information

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

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

Social Security #: _____ Birth Date: _____ DL# _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Employer #: _____

Health History

Name of Physician: _____ Phone: _____ Date last seen: _____
Are you now under the care of a physician? ☐ Yes ☐ No
Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
Please list any medications you are currently taking: _____

Please list any medications you are allergic to: _____

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

☐ AIDS/HIV	☐ Dizziness	☐ Hepatitis	☐ Penicillin Allergy	☐ Tuberculosis
☐ Anemia	☐ Epilepsy	☐ High Blood Pressure	☐ Pregnancy	☐ Tumors
☐ Arthritis	☐ Excessive Bleeding	☐ Jaundice	Due date: _____	☐ Ulcers
☐ Artificial Joints	☐ Fainting	☐ Kidney Disease	☐ Radiation Treatment	OTHER:
☐ Asthma	☐ Glaucoma	☐ Liver Disease	☐ Respiratory Problems	☐ _____
☐ Blood Disease	☐ Hay Fever	☐ Mental Disorders	☐ Rheumatic Fever	☐ _____
☐ Cancer	☐ Head Injuries	☐ Metal or Latex Allergy	☐ Sinus Problems	
☐ Codeine Allergy	☐ Heart Disease	☐ Other Allergies:	☐ Stomach Problems	
☐ Diabetes	☐ Heart Murmur	_____	☐ Stroke	

- Do you smoke or chew tobacco? ☐ Yes ☐ No
- Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No

Dental History

Date of Last Dental Visit: _____ Reason for this visit: ☐ New Patient Exam ☐ ER ☐ Consultation ☐ Other: _____
- Do you brush and floss on a daily basis? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
- Are you having pain or discomfort at this time? ☐ Yes ☐ No
- Are you nervous or apprehensive about your dental treatment? ☐ Yes ☐ No
- Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No
- Have you ever had an unusual reaction to dental anesthetic? ☐ Yes ☐ No

Do you have or have you ever had any of the following? Please check those that apply:

☐ Bleeding or sore gums	☐ Food trapped between teeth	☐ Periodontal (gum) Treatment	☐ Clinching or grinding teeth
☐ Loose/shifting teeth	☐ Complications from extractions	☐ Orthodontic Treatment (Braces)	☐ Pain/clicking/popping of jaw
☐ Sensitivity to hot/cold/sweets			

Health Questionnaire Acknowledgment and Consent to Proceed

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment. I authorize Dr. Mark L. Pettit and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval. I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____ 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: _____

Email: _____ DL# _____ Best time to call: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Name and number of someone not living with you: _____

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 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, Address and Phone: _____

_____

_____

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 by cash or credit card at the time services are performed.

Insurance Assignment and Release

I _____ assign directly to Dr. Alexandra Garcia all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The office will not accept assignment for secondary insurance claims. The patient or responsible party will need to file all secondary claims.

The above named doctor may use my minor/child's health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient agrees to be financially responsible for failed, cancelled, or rescheduled appointment fees. These fees range in price from $25 up to, but not in excess of , $125 depending on the nature of treatment for which you were appointed. These fees are not billable to insurance and are thus payable directly by patient. Our office requires a minimum of 48 hours notice prior to a scheduled appointment to exempt you from the failed appointment fees.

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 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 ten (10) 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. An additional 33% will be added to my account if turned over to a collection agency.

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 guarantor of payment/responsible party