Gregory Moffitt, D.D.S.

Todays Date: _____

Patient Name: _____
(Last) (First) (Middle)

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Work Phone # _____

Cellular Phone # _____

Date of Birth: _____ Age: _____ Male ☐ Female ☐

Marital Status: _____ Social Security # _____

Responsible Party Information

Name: _____ S.S.# _____

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Work Phone #: _____

Relationship to Patient: _____ Birth Date: _____

Spouses Name: _____ Work Phone: _____

Spouses Date of Birth: _____ Spouses S. S. #: _____

Insurance Information

Policy Holder: _____ S.S. #: _____

Employer: _____ Group #: _____

Insurance Company: _____

Insurance Address: _____

Emergency Contact Information

Name of nearest relative not living with you: _____

Relationship: _____ Phone #: _____

Address: _____ Zip Code: _____

What is your reason for this dental visit? _____

When was your last dental visit? _____ Last X-rays: _____

Are you interested in whiter teeth? ☐ Yes ☐ No

Are there any other dental concerns?: _____

Name:_____ **Date of Birth:**_____

Information that you feel insignificant could be related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:	**Yes**	**No**
Any heart problems	☐	☐
Heart Attack	☐	☐
Angina	☐	☐
Bypass	☐	☐
Pacemaker	☐	☐
Stroke	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Heart Murmur*	☐	☐
Mitral Valve Prolapse*	☐	☐
Heart Valve Replacement*	☐	☐
Rheumatic Fever*	☐	☐
Artificial Joint (hip/knee)	☐	☐
Pins or Screws*	☐	☐
Any Bleeding Disorders	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Sickle Cell Trait	☐	☐
Blood Transfusions	☐	☐
HIV/AIDS	☐	☐
Cancer/ Tumor	☐	☐
Other Growths	☐	☐

	Yes	**No**
Do you smoke	☐	☐
Lung/ Breathing Problems	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Sinus Trouble	☐	☐
Diabetes	☐	☐
Difficulty w/ Hearing	☐	☐
Liver Problems/ Dysfunction	☐	☐
Hepatitis/ Jaundice	☐	☐
Kidney Problems/ Dysfunction	☐	☐
Stomach Trouble/ Ulcers	☐	☐
Alcoholism	☐	☐
Drug Abuse	☐	☐
Nervous or Mental Disorder	☐	☐
Epilepsy or Seizures	☐	☐
Thyroid Problems	☐	☐
Adrenal/ Pituitary Problems	☐	☐
Sexually Transmitted Diseases	☐	☐
Other infections Diseases	☐	☐
Chemotherapy/ Radiation	☐	☐

Allergic reaction to (hives/ swelling)	**Yes**	**No**
Penicillin	☐	☐
Erythromycin	☐	☐
Sulfa	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Local Anesthetic (Novocain)	☐	☐
Any other allergies?	☐	☐

If Yes please list _____

_____

_____

*Do you take, or have you been told to take antibiotic premedication prior to dental appointments? ☐ Yes ☐ No ☐ Don't Know

Name of Antibiotic:_____

Are you currently being treated by a physician?

☐ Yes ☐ No Why?_____

Physicians name, address & phone #_____

_____

Are you pregnant? ☐ Yes ☐ No

Are you currently taking any medications, pills or tonics?

☐ Yes ☐ No List: _____

_____

_____

_____

_____

Updates: _____ _____ _____ _____ _____ _____ _____ _____

Are there any other problems or conditions relating to your medical history that has not been mentioned? ☐ Yes ☐ No

CONSENT AND ACKNOWLEDGMENT

I, the patient, or the Parent or Guardian of a minor patient, hereby acknowledge the following information has been read by me, that I understand the information fully and that I agree this day to the following:

A. That a $50.00 fee will be charged for any failed appointment, where the Patient or the Parent or Guardian of a minor Patient, has not provided **24 hours** advance notice. If there are **2 failures** we will not be able to see the patient in our office anymore.

B. I am responsible for all fees for service rendered by **Gregory Moffitt D.D.S. LLC.,** that were rendered to the patient and which are not paid by my dental insurance. Failure to supply proper forms and information will necessitate payment in full by the patient Parent, or Guardian.

C. That will make prompt payment to **Gregory Moffitt D.D.S. LLC.,** for all charges by the patient; and a $50.00 monthly service charge shall be assessed for any charge not paid by me within (90) days of billing, beginning from the date of services were rendered.

D. I further agree that if this matter is referred to a collection agency, I will pay the collection costs, not to exceed 40% of the amount I owe. Also, a returned check fee will be charged according to bank service fees assessed.

E. I hereby give my consent as Patient, Parent or Guardian of a minor Patient, if applicable to the Patient, to **Gregory Moffitt D.D.S. LLC,** to treat my child. I am aware that be behavior modification procedures may be invoked to facilitate treatment. I also consent to allow the staff to assist Dr. Moffitt and /or his Associates in the treatment of my child. I acknowledge, attest and agree that no guarantee of success, or degree of success, has been given or implied.

F. That my consent and adherence to these terms and conditions contained herein shall begin this date and extend to all future treatment (s) rendered by **Gregory Moffitt D.D.S LLC.**

(seal)

_____ _____

Patient Date

(seal)

_____ _____

Parent or Guardian of Patient Date

(If Patient is a Minor) responsible party