WELCOME TO OUR OFFICE

PATIENTS NAME: _____ M / F

(If patient is a child)

PARENTS NAME: _____

PATIENTS DATE OF BIRTH: _____ SS# _____

MARRIED: Yes / No

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL: _____ HOME: _____ WORK: _____

EMAIL: _____

PREFERRED CONTACT METHOD: Cell ( ) Home ( ) Email ( ) Work ( )

HOW DID YOU HEAR OF OUR OFFICE? _____

INSURANCE COMPANY: _____

INSURANCE PHONE NUMBER: _____

POLICY HOLDER NAME: _____ DOB: _____

PATIENTS RELATIONSHIP TO POLICYHOLDER: _____

MEMBER/ID #: _____ GROUP# _____

Medical History for New Patient

Last Name: First Name: Birthdate:

Name of Medical Doctor: City/State:

Emergency Contact Phone Relationship

Are you allergic to any of the following? Or list Other allergies:

- ☐ Anesthetic
- ☐ Aspirin
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

Do you have any of the following medical conditions:

- ☐ Asthma
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Sinus Trouble
- ☐ Ulcers
- ☐ Epilepsy or Seizures
- ☐ Latex Sensitivity
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Psychiatric Treatment
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Bleeding Problems
- ☐ Pregnancy
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Pacemaker
- ☐ Rheumatic Fever

List all other conditions you are currently being treated for:

_____

_____

_____

List all Medications:

_____

_____

_____

Unusual reaction to dental injections? _____

Reason for today's visit _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Date: 09/07/2017

Patient's Signature

Doctor's Signature

FINANCIAL AGREEMENT:

Name:_____DOB:_____

- **Payment is due at time of service, unless other financial arrangements have been made prior to the appointment.**
- For patient convenience, Thomas O'Leary Dentistry will file claims to the insurance company and receive payment directly from the carrier. They may release any information to the carrier for processing of claim.
- Every effort will be made to help with your insurance, but, if they do not pay as expected, the patient/parent will be responsible for any unpaid balance.
- For minor children, the parent accompanying them to the office will be responsible for any patient portion that will be due at time of service.
- Any unpaid balance over 90 days will be given over to our Attorney for Collection Process.
- **We require all appointments to be confirmed at least 24 hours in advance. We reserve the right to cancel any unconfirmed appointment. Patient will be charged $50.00 for No-Show appointments and appointments canceled less than 24 hours in advance.**

I have read and understand the financial agreement.

Sign:_____date:_____

Privacy Policies:

I have had the opportunity to read the contents of the Notice of Privacy Practices. I understand and give my permission to your use and disclosure of my health information in order to carry out treatment, payment and operation. I also understand I have the right to revoke permission.

Sign:_____date:_____