CONFIDENTIAL

PATIENT INFORMATION

Imlay City Dental, P.L.L.C.
216 East Third Street
Imlay City, Michigan 48444
810-724-8080

NAME ______ *First* ______ *Initial* ______ *Last* ______ DATE of BIRTH ___/___/___

STREET ______ CITY ______ STATE ______ ZIP ______

E-MAIL ______ HOME PHONE ______ CELL PHONE ______

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENTS OR PARENT/GUARDIAN'S EMPLOYER ______ WORK PHONE ______

BUSINESS ADDRESS ______ CITY ______ STATE ______ ZIP ______

SPOUSE OR PARENT/GUARDIAN'S NAME ______ EMPLOYER ______

IF PATIENT IS A STUDENT, NAME OF COLLEGE ______ CITY ______ STATE ______

BY WHOM WERE YOU REFERRED TO US? ______ MAY WE THANK THEM? ______

PERSON TO CONTACT IN AN EMERGENCY ______ PHONE ______

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT ______ RELATIONSHIP TO PATIENT ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______

E-MAIL ______ HOME PHONE ______ CELL PHONE ______

DRIVERS LICENSE # ______ BIRTHDATE ___/___/___ FINANCIAL INSTITUTION ______

EMPLOYER ______ WORK PHONE ______

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______ RELATIONSHIP TO PATIENT ______

BIRTHDATE ___/___/___ SOCIAL SECURITY # ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE ______ ZIP ______

INSURANCE COMPANY ______ GROUP# ______ UNION OR LOCAL# ______

INS. CO. ADDRESS ______ CITY ______ STATE ______ ZIP ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______ RELATIONSHIP TO PATIENT ______

BIRTHDATE ___/___/___ SOCIAL SECURITY # ______ DATE EMPLOYED ______

NAME OF EMPLOYER ______ WORK PHONE ______

EMPLOYER ADDRESS ______ CITY ______ STATE ______ ZIP ______

INSURANCE COMPANY ______ GROUP# ______ UNION OR LOCAL# ______

INS. CO. ADDRESS ______ CITY ______ STATE ______ ZIP ______

FINANCIAL ARRANGEMENTS

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT.
PLEASE CHECK THE OPTION YOU PREFER. PAYMENT IN FULL AT EACH APPOINTMENT.

☐ CASH ☐ PERSONAL CHECK
☐ CREDIT CARD (VISA, MC, DISCOVER)
☐ I WISH TO DISCUSS THE DENTAL OFFICE'S POLICY

X ______
SIGNATURE OF PATIENT-OR-PARENT/GUARDIAN IF MINOR

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge *of 1.5% on the balance then* unpaid and owed will be assessed each month (if allowed by law) I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional service. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

PATIENT MEDICAL HISTORY

Imlay City Dental, P.L.L.C.
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810-724-8080

PATIENT NAME ______________ **Date of Birth** ______________

MEDICAL DOCTOR ______________

OFFICE PHONE ______________ **Date of Last Exam** ______________

1. Are you under medical treatment now? YES ☐ NO ☐
2. Have you ever been hospitalized for any surgical operation or serious illness, within the last 5 years? YES ☐ NO ☐
   If yes, please explain ______________
3. Are you taking any medication(s) including non-prescription medicine? YES ☐ NO ☐
   If yes, what medication(s) are you taking? ______________
4. Have you ever taken Fen-Phen/Redux? YES ☐ NO ☐
5. Do you use tobacco? YES ☐ NO ☐
6. Do you use controlled substances? YES ☐ NO ☐
7. Are you wearing contact lenses? YES ☐ NO ☐
8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? YES ☐ NO ☐
9. Are you allergic to or have you had any reactions to the following?
   - Local Anesthetics (e.g. Novocain) YES ☐ NO ☐
   - Penicillin or any other Antibiotics YES ☐ NO ☐
   - *(please list)* ______________
   - Sulfa Drugs YES ☐ NO ☐
   - Barbiturates YES ☐ NO ☐
   - Sedatives YES ☐ NO ☐
   - Iodine YES ☐ NO ☐
   - Aspirin YES ☐ NO ☐
   - Any Metals (e.g. nickel, mercury, etc.) YES ☐ NO ☐
   - Latex Rubber YES ☐ NO ☐
   - Other (please list) ______________
10. Women Only:
    - a) Are you pregnant or think you maybe? YES ☐ NO ☐
    - b) Are you nursing? YES ☐ NO ☐
    - c) Are you taking oral contraceptives? YES ☐ NO ☐
11. Do you have or have you had any of the following?

Condition	YES	NO
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐

Other ______________

COMMENTS

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______________ ______________ ______________ ______________

Signature of patient (or parent/guardian of minor) **Date** **Signature of Dentist** **Date**