Arrow Smile Dental, ***A practice of Victor M. Rosales, D.D.S., Inc.***

Patient Information

DATE: _____

Patient Name: _____ ☐Minor ☐Adult ☐Married ☐Single/Div/Sep
Last First M.I.

Home Address of Patient: _____
Street Apt # City State Zip

Birthdate: ___/___/___ Gender: ☐Male ☐Female SS# ___-___-___

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Incase of emergency, Person to contact: _____ Phone: _____

Email Address: _____

Were you referred by someone to our office, if yes who? _____

State Identification Number (Drivers License): _____

Responsible Party for this Account (If different from above)

Name: _____ Relationship to Patient: _____

Home Address: _____
Street Apt # City State Zip

Birthdate: ___/___/___ SS# ___-___-___ Home Phone: _____

State Identification Number (Drivers License): _____

Primary Dental Coverage

If you do not have Dental Insurance, please check this box: ☐ ☐HMO ☐PPO

Name of Employer/School: _____ Phone: _____

Address of Employer: _____
Street Suite # City State Zip

Dental Ins. Company #1: _____ Group #: _____ Policy #: _____

Dental Ins. Company #2: _____ Group #: _____ Policy #: _____

Financial Obligation

Payment is expected when services are rendered. It is your responsibility to discuss with the administrative staff payment options before treatment commences. All payments plans will be provided in writing and signed by the patient.

Other Financial Obligations:

1. I agree to pay all reasonable collection cost and attorney fees in the event of any default of balanced owed.
2. I agree to pay a service charge of $25.00 for all returned checks.
3. In the event of a cancellation, when 24 hours notice has not been given, a $25.00 charge will be placed on your account.
4. Any estimate given is guaranteed for 90 days.

I hereby authorize the doctor to perform any and all form of treatment, medication, and therapy that may be indicated in connection with proper dental care of the above patient. I the undersigned shall be responsible for the payment of charges incurred for the services rendered and shall be responsible for payment in excess of existing insurance coverage. Also permission is granted to perform necessary treatment if patient is a minor.

Patient Signature (Parent if Patient is a minor): _____ Date: _____

Doctor's Signature of Arrow Smile Dental: _____ Date: _____

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Medical History of Patient **Patient Name:** _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No If yes, Explain: _____.
Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, Explain: _____.
Have you ever had a serious head injury? ☐Yes ☐No If yes, Explain: _____.
Are you taking any medications, pills or drugs? ☐Yes ☐No If yes, Explain: _____.
Do you take, or have you taken, Phem-Fen or Redux? ☐Yes ☐No If yes, Explain: _____.
Are you on a special diet? ☐Yes ☐No _____.
Do you use tobacco? ☐Yes ☐No
Do you use controlled substances? ☐Yes ☐No

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex
☐Other, If yes, explain: _____

Women are you:

Pregnant/Trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Do you have, or have you had, any of the following?

Aids/HIV Positive	☐Yes ☐No	Cortisone Medicine	☐Yes ☐No	Hemophilia	☐Yes ☐No	Renal Dialysis	☐Yes ☐No
Alzheimer's Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Drug Addiction	☐Yes ☐No	Hepatitis B/C	☐Yes ☐No	Rheumatism	☐Yes ☐No
Anemia	☐Yes ☐No	Easily Winded	☐Yes ☐No	Herpes	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Angina	☐Yes ☐No	Emphysema	☐Yes ☐No	High Blood Pres.	☐Yes ☐No	Shingles	☐Yes ☐No
Arthritis/Gout	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Artificial Heart Value	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Hypoglycemia	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Excessive Thrust	☐Yes ☐No	Irregular Heart beat	☐Yes ☐No	Spina Bifida	☐Yes ☐No
Asthma	☐Yes ☐No	Fainting Spells/Dizziness	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Stomach/Intes. Dis.	☐Yes ☐No
Blood Disease	☐Yes ☐No	Frequent Cough	☐Yes ☐No	Leukemia	☐Yes ☐No	Stroke	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No	Liver Disease	☐Yes ☐No	Swelling of Limbs	☐Yes ☐No
Breathing Problem	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Low Blood Pres	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Genital Herpes	☐Yes ☐No	Lung Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Cancer	☐Yes ☐No	Glaucoma	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Hay Fever	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Tumors or Growths	☐Yes ☐No
Chest Pains	☐Yes ☐No	Heart Attack/Failure	☐Yes ☐No	Parathyroid Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Cold Sores/Fever Blisters	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Congenital heart Disorder	☐Yes ☐No	Heart Pace Maker	☐Yes ☐No	Radiation Treatments	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Convulsions	☐Yes ☐No	Heart Trouble/Disease	☐Yes ☐No	Recent Weight Loss	☐Yes ☐No		

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, explain: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date: _____

Office use only – DO NOT WRITE IN THIS BLOCK

1st Recall / Signature _____ Date: _____

2nd Recall / Signature _____ Date: _____

3rd Recall / Signature _____ Date: _____