

### 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:**

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

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Bleeding or sore gums          | <input type="checkbox"/> Food trapped between teeth     | <input type="checkbox"/> Periodontal (gum) Treatment    | <input type="checkbox"/> Clinching or grinding teeth  |
| <input type="checkbox"/> Loose/shifting teeth           | <input type="checkbox"/> Complications from extractions | <input type="checkbox"/> Orthodontic Treatment (Braces) | <input type="checkbox"/> Pain/clicking/popping of jaw |
| <input type="checkbox"/> 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. George Garbis 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.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

### 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: \_\_\_\_\_

**Secondary**  
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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any and all benefits from insurance companies and other third party payors that are payable to Patient or on behalf of Patient for dental care services and related payments for services rendered or provided to Patient are hereby transferred and assigned to Garbis Dental Associates for the exclusive purpose of paying for charges associated with dental care services provided to Patient in this office. It is understood and intended that all insurance companies and other third party payors will pay benefits directly to Garbis Dental Associates in payment of Garbis Dental Associates' charges and the charges of any other health care providers for whom Garbis Dental Associates is authorized to bill in connection with health care services provided to Patient.

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 60 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.

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_