BLUEBONNET DENTAL
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Anna, TX 75409

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PATIENT INFORMATION

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Cell:_____
Please list at least two contact numbers.

Email Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact Name:_____**Phone:**_____

HEALTH INFORMATION

Do you currently have or have you EVER had any of the following? Please check all that apply:

- ☐ AIDS/HIV +
- ☐ Medication Allergies:
  _____
  - ☐ Codeine Allergy
  - ☐ Penicillin Allergy
  - ☐ Latex Allergy
  - ☐ Seasonal Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer/Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Growths
- ☐ Head Injuries
- ☐ Heart Disease
  - ☐ By Pass Surgery
  - ☐ Stent Placement
  - ☐ Valve Replacement
  - ☐ Pacemaker
  - ☐ Heart Murmur
  - ☐ Heart Defect
- ☐ Hepatitis **A, B, C, D, E**
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Jaundice
- ☐ Pregnant (Currently)
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Bronchitis/COPD
- ☐ Venereal Disease/STDs

OTHER:
_____
_____
_____

Current Medications:
(List all Medications you are taking; use back of page or attach list if needed)
_____
_____
_____
_____

Date of last dental visit:_____ Reason for Today's visit:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health/medications, it is my responsibility to inform the doctor(s) at my next appointment.

_____ _____
Signature of patient/parent or guardian **Date**

PARENT OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ parent/guardian ☐ the person responsible for payment ☐ Check if address is the same as above

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

INSURANCE INFORMATION

Primary Insurance information:
The following is for: ☐ Self ☐ Patient's spouse ☐ Dependent Child ☐ Other (Please specify)_____

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Date of Birth: _____

Insurance Plan Name and Address: _____

Member ID #: _____ Group #: _____

Insured's Employer Name: _____ Occupation: _____

☐ Check if address is the same as previous page

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

INSURANCE PATIENTS: PLEASE READ CAREFULLY

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.

_____ **Date:** _____ **Relationship to Patient:** _____
(Signature of patient or guarantor of payment/responsible party)

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

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 in cash at the time services are performed. I understand that as part of treatment planning, a reasonable amount of radiographs/x-rays must be taken to ensure proper diagnosis by the doctor and if I choose to decline such x-rays, this office/doctor reserves the right to refuse treatment. I further understand that the fee estimate listed and given to me for my proposed dental care can only be extended for a period of six months from the date of the examination. 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 if necessary.

I have read the above conditions of treatment and payment and agree to their content. I have also had the opportunity to review and agree to the HIPAA privacy policy for this office.

_____ **Date:** _____ **Relationship to Patient:** _____
(Signature of patient, parent or guardian)