Patient Information

Patient Name: ____ Date: ________________
Last First MI

What name do you go by? ________________ SSN: _______________ Birth Date: ________________

Sex: □ M □ F Marital Status: □ Under 18yo □ Single □ Married □ Partnered □ Other: __________

Phone: (C) ____________________ (H) ______________________ (W) __________________ Ext: ______

E-mail: ________________________________

Address: ____
Street Apt # City State Zip Code

Emergency Contact: _______________________ Phone: ______________ Relationship to Patient: __________

Health Information

Date of Last Dental Visit: __________________ Reason for Today's Visit: ____________________________

Have you ever had any of the following? Please check those that apply:

- □ HIV+
- □ Anemia
- □ Arthritis
- □ Artificial Joints
- □ Asthma
- □ Blood Disease
- □ Cancer
- □ Cold Sores
- □ Codeine Allergy
- □ Diabetes
- □ Dizziness
- □ Epilepsy
- □ Excessive Bleeding
- □ Fainting
- □ Glaucoma
- □ Hay Fever
- □ Head Injuries
- □ Heart Disease
  - □ Heart Murmur
  - □ Mitral Valve Prolapse
- □ Hepatitis
- □ High Blood Pressure
- □ Jaundice
- □ Kidney Disease
- □ Liver Disease
- □ Mental Disorders
- □ Nervous System Disorders
- □ Pacemaker
- □ Penicillin Allergy
- □ Pregnancy (Current)
  Due Date: __________
- □ Radiation Therapy
- □ Respiratory Problems
- □ Rheumatic Fever
- □ Sinus Problems
- □ Stomach Problems
- □ Stroke
- □ Tuberculosis
- □ Ulcers

DRUG ALLERGIES:

____
____
____

LIST MEDICATIONS:

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- 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, I will inform the doctor at the next appointment without fail.

X ____ Date: ________________
Signature of patient, parent, or guardian

Referral Information

How did you hear about our office? □ Sign/Drove by □ Internet Search □ Insurance Company: __________

□ Another patient or office (name): ____

□ Advertisement (name of publication): ______________________ □ Other: ______________________

Patient Consent

Clinical

1. I authorize William Castle, DDS, PLLC to perform all recommended treatment.
2. I authorize the practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third party payors and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment of all services rendered on my behalf. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collections costs, including reasonable attorney fees.

Insurance

5. I authorize the practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services, rendered, or recommended treatment.
6. I authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf, and in my name listed as "signature on file" and assign to the practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

Grievance Policy

7. I understand that, while I am urged to communicate directly with the office if I am dissatisfied with the service provided, I may file a formal grievance by requesting a form from the front desk. Our office will respond within 30 days of receipt of the grievance.

Missed/Cancelled Appointment Policy

8. I acknowledge that the office requests a 24-hour notice so that my appointment time may be given to another patient. If I am unable to make the appointment and do not give a 24-hour notice, I could be charged a $50.00 cancellation fee.

I have read this Patient Consent and agree to the terms and conditions herein.

Patient's or Responsible Party's signature: ______________________________________

Patient's Name (print): ______________________________________

Date: ______________________________________

Patient Consent/Guidelines for Parent or Legal Guardian

Clinical

1. As the parent/legal guardian of ____________________________________ ("Patient"), I authorize William Castle, DDS, PLLC to perform all recommended treatment on the Patient.
2. I authorize the practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third party payors and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment of all services rendered on behalf of the Patient. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collections costs, including reasonable attorney fees.

Insurance

5. I authorize the practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about the Patient's medical history, services, rendered, or recommended treatment.
6. I authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf or on the Patient's behalf, and in my name listed as "signature on file" and assign to the practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

Grievance Policy

7. I understand that, while I am urged to communicate directly with the office if I am dissatisfied with the service provided, I may file a formal grievance by requesting a form from the front desk. Our office will respond within 30 days of receipt of the grievance.

Missed/Cancelled Appointment Policy

8. I acknowledge that the office requests a 24-hour notice so that the Patient's appointment time may be given to another patient. If the Patient is unable to make the appointment, and I do not give a 24-hour notice, I could be charged a $50.00 cancellation fee.

I have read this Patient Consent/Guidelines and agree to the terms and conditions herein.

Patient's Name: ____ DOB: ______________________

Signature of Parent/Guardian: ___________________________________ Date:_______________________

Name of Parent/Guardian (print): ___________________________________

Relationship to Patient: ____