Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: ☐ M ☐ F Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ Social Security #: _____

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

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check Yes or No:

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Excessive Bleeding	☐	☐	Mental Disorders	☐	☐	Codeine Allergy
☐	☐	Allergies _____	☐	☐	Fainting	☐	☐	Mitral Valve Prolapse	☐	☐	Penicillin Allergy
			☐	☐	Glaucoma	☐	☐	Nervous Disorders			
☐	☐	Anemia	☐	☐	Growths	☐	☐	Osteoporosis	☐	☐	Other Medication Allergies
☐	☐	Arthritis	☐	☐	Head Injuries	☐	☐	Pacemaker	OTHER:		
☐	☐	Artificial Joints	☐	☐	Hay Fever	☐	☐	Respiratory problems	☐		_____
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Radiation treatment	☐		_____
☐	☐	Blood Disease	☐	☐	Heart Murmur	☐	☐	Rheumatism			
☐	☐	Cancer	☐	☐	Heart Valve Damage	☐	☐	Sinus Problems			
☐	☐	Congenital Heart Defect	☐	☐	Hepatitis	☐	☐	Stomach Problems	Women Only		
			☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐	**Pregnancy**
☐	☐	Diabetes	☐	☐	Jaundice	☐	☐	Tuberculosis	Due date: _____		
☐	☐	Dizziness	☐	☐	Kidney Disease	☐	☐	Tumors	☐	☐	Breastfeeding
☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Ulcers	☐	☐	Birth Control
						☐	☐	Venereal Disease			

- 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: _____
- Have you ever taken Phen Fen or Redux? ☐ Yes ☐ No
  If yes, do you require antibiotic pre-medication for dental care as a result of taking these medications? ☐ Yes ☐ No
- Do you require antibiotic pre-medication for dental care for any condition? ☐ Yes ☐ No
- Are you taking any over the counter or prescription medications? ☐ Yes ☐ No
  If yes, please list: _____

_____

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 doctors at the next appointment without fail.

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: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

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 and Address: _____

_____

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 and Address: _____

Office Policies

In order to provide high quality dentistry at the most reasonable fee possible, we ask that our patients follow our office policies listed below.

1. Maintain regular dental examinations. For most people this is every six months.
2. Keep scheduled appointments. A minimum of 24-hour notice is required or a fee will be added to the account.
3. Work towards maintaining good oral health. We will provide treatment recommendations to guide you toward this goal.
4. Pay at the time of service. We do not carry balances but do provide other payment options.

_____ Date: _____
Signature

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 in cash 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.

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/We agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit. If my account is turned over to a collection agency I/we agree to pay a 40% collection fee which will be added to the outstanding balance.
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 five (5) 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.

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.

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

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

Health Questionnaire Acknowledgement 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. Cameron Buhler and/or Dr. Forrest Buhler and/or such associates or assistants as the doctors 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, 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 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:_____ Date:_____
(Patient, legal guardian or authorized agent of patient)