ASA: I II III IV V
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI

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

Social Security #: _____ Date of birth: _____

Address: _____
Street Apt/Unit #

_____
City State Zip Code

Phone: _____ Email: _____

Health Information

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

☐ **Allergies (check all that apply):** ☐ **Seasonal** ☐ **Nuts** ☐ **Shellfish/Seafood** ☐ **Metals** ☐ **Latex** ☐ **Allergy to Medications:** _____ ☐ **Other:** _____			
☐ **Anemia**	☐ **Glaucoma**	☐ **Liver Disease**	☐ **Tuberculosis**
☐ **Arthritis**	☐ **Growths/Tumors**	☐ **Lupus**	☐ **Tumors**
☐ **Artificial/Prosthetic Joints** If yes → ☐ Knee ☐ Hip ☐ Shoulder ☐ Titanium Plates ☐ Other _____ Orthopedic Surgeon: _____ Doctor's Full Name Phone Number			
☐ **Asthma**	☐ **Hay Fever**	☐ **Mental Disorders**	☐ **Codeine Allergy**
☐ **Blood Disease**	☐ **Head Injuries**	☐ **Nervous Disorders**	☐ **Penicillin Allergy**
☐ **Blood Thinners**	☐ **Heart Disease**	☐ **Oral Lesions/ Ulcers**	☐ **Radiation Treatment**
☐ **Cancer**	☐ **Heart Murmur**	☐ **Pacemaker**	☐ **Smoker**
☐ **Chemotherapy**	☐ **Hepatitis** If yes, what type → ☐ A ☐ B ☐ C ☐ Non-AB		☐ **Stroke**
☐ **Diabetes** Type: _____	☐ **High Blood Pressure**	☐ **Pregnant** If yes → Due date: _____	
☐ **Dizziness**	☐ **HIV/AIDS**	☐ **Respiratory Problems**	☐ **Thyroid Disease**
☐ **Excessive Bleeding**	☐ **Jaundice**	☐ **Rheumatic Fever**	☐ **Other:**
☐ **Fainting**	☐ **Kidney Disease**	☐ **Sinus Problems**	
Medications:			

- Have you ever had any complications following dental treatment? □ **Yes** □ **No**
  If yes, please explain:
  _____

- Have you ever had any allergic reaction or complication with dental anesthesia: □ **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 currently under the care of a physician: □ **Yes** □ **No**
  If yes, please explain:
  _____

- Name of Physician: _____ Phone: _____

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 my doctors at the next appointment without fail.

Signature: _____ Date: _____

Insurance Information

Name of Insured: _____ Is insured a patient: □ **Yes** □ **No**
Last First MI

Insured's D.O.B.: _____ Insured's Employer Name: _____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other _____

Insurance Company Name: _____ Member I.D. # _____

Group # _____ Insurance Company Phone # _____

Consent for Treatment

I hereby consent to and authorize dental treatment rendered by Dr. Kenneth Richard DuBois, II, Dr. Kim-Hanh Nguyen, Dr. Anne DuBois, Amanda Helm, RDH and any temporary providers who this office sees fit to render dental care on behalf of the above listed providers. I hereby consent to the release of dental or incidental information that may be necessary for dental care, records release &/or transfers, insurance claims and any other reasonable and customary process by this dental office. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This dental office cannot render services on the assumption that the charges will be paid by an insurance company. DuBois Dentistry 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. I authorize direct payment of insurance benefits to be paid to this office on my behalf. I understand that I will be charged 1.5% monthly interest (18% annual interest) on any balance owed over 90 days old. I further understand that if it is necessary to turn this account over to a collection agency, I will be held responsible for the balance due along with any applicable interest, collections and attorney's fees.

_____

Signature of patient, parent, or guardian **Date** **Relationship to Patient**