

# Archie Imperial DDS, PC

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_ Drivers License # \_\_\_\_\_  
Address: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Street Apt #  
City State Zip Code

## Health Information

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

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

- If you could, what would you change about your smile? \_\_\_\_\_
- 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 doctors at the next appointment without fail.

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

## DENTAL HISTORY

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you floss daily? Are your teeth sensitive to hot/cold/sweets? Do you have any pain in your teeth?  
Do you have any metal allergies? Difficulty opening/closing/chewing?  
Have you had any difficult extractions? Do you clench or grind your teeth?  
Do your gums bleed when brushing or flossing? Have you ever had orthodontic treatment?

### 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 \_\_\_\_\_

### Dental Plan Information

**Primary**

Name of Dental Plan: \_\_\_\_\_

Street  
Employer Name: \_\_\_\_\_

### 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 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of 3 months from the date of the patient examination.

I agree to the above and give consent for my dental care as necessary by Dr. Imperial and staff.

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

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

### Notice of Receipt of Privacy Policy ( You may refuse to sign )

I \_\_\_\_\_ have received a copy of this offices Notice of Policy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I will allow Dr. Imperial's office to send reminder postcards via mail. Initials \_\_\_\_\_

\*\*\* Office use Only\*\*\* We attempted to obtain signature, however :

Pt refused to sign      Communication Barrier      Emergency Situation      Other \_\_\_\_\_      Emp Init \_\_\_\_\_