IVANHOE DENTAL GROUP LTD.

PATIENT INFORMATION Today's Date _____

Name _____ Birth Date _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Drivers License # _____

Employer _____ Date Employed _____

Employer Address _____ City _____ State _____ Zip _____

Is this person under age 18? ☐ Yes ☐ No ☐ Male ☐ Female ☐ Single ☐ Married

If so, name of Parent(s) or Guardian(s) _____

Email _____

Is this person a student? ☐ Yes ☐ No Name of School _____

Who may we thank for referring you _____

Who may we contact in case of emergency? _____ Phone # _____

RESPONSIBLE PARTY INFORMATION

Name _____ Birth Date _____ SS# _____

Address _____ City _____ State _____ Zip _____

Driver's License # _____ Relationship to Patient _____

Home Phone _____ Work Phone _____

Employer _____ Date Employed _____ Union # _____

Employer Address _____ City _____ State _____ Zip _____

Is this person a patient in this office? ☐ Yes ☐ No

Insurance Co. Name _____ Group # _____ Policy I.D. _____

Insurance Co. Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Birth Date _____ SS# _____

Address _____ City _____ State _____ Zip _____

Driver's License # _____ Relationship to Patient _____

Home Phone _____ Work Phone _____

Employer _____ Date Employed _____ Union # _____

Employer Address _____ City _____ State _____ Zip _____

Is this person a patient in this office? ☐ Yes ☐ No

Insurance Co. Name _____ Group # _____ Policy I.D. _____

Insurance Co. Address _____ City _____ State _____ Zip _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. I understand and agree that a 1 1/2% per month interest charge will be added to this account for any unpaid balance over 90 days unless a written financial agreement has been established.

Date _____ Signature _____

MEDICAL HISTORY

Do you have dentures or partials? ☐ Yes ☐ No If yes date they were placed _____

Physician _____ Office Phone _____ Date of Last Exam _____

Are you under medical treatment now? .....☐ Yes ☐ No

Have you been hospitalized for surgery or serious illness in the last year? .....☐ Yes ☐ No

Please Explain _____

_____

Are you taking any medications .....☐ Yes ☐ No

Please List _____

_____

Have you ever taken Phen-fen/Redux? .....☐ Yes ☐ No

Do you use tobacco? .....☐ Yes ☐ No

Are you wearing contact lenses? .....☐ Yes ☐ No

Are you allergic to or have you had any reactions to the following?

Local Anesthetic (Novocaine)..... ☐ Yes ☐ No

Penicillin or other antibiotics ..... ☐ Yes ☐ No

Sulfa Drugs..... ☐ Yes ☐ No

Barbiturates..... ☐ Yes ☐ No

Sedatives..... ☐ Yes ☐ No

Iodine..... ☐ Yes ☐ No

Aspirin ..... ☐ Yes ☐ No

Any metals (nickel, mercury, etc.)..... ☐ Yes ☐ No

Latex Rubber..... ☐ Yes ☐ No

Other..... ☐ Yes ☐ No

Women: are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No

Do you have or have you ever had any of the following?

High Blood Pressure .....☐ Yes ☐ No
Heart Attack .....☐ Yes ☐ No
Rheumatic Fever .....☐ Yes ☐ No
Swollen Ankles .....☐ Yes ☐ No
Fainting/Seizures.....☐ Yes ☐ No
Asthma .....☐ Yes ☐ No
Low Blood Pressure .....☐ Yes ☐ No
Epilepsy/Convulsions .....☐ Yes ☐ No
Leukemia .....☐ Yes ☐ No
Diabetes .....☐ Yes ☐ No
Kidney Diseases.....☐ Yes ☐ No
AIDS or HIV Infection.....☐ Yes ☐ No
Thyroid Problem .....☐ Yes ☐ No

Heart Disease .....☐ Yes ☐ No
Cardiac Pacemaker .....☐ Yes ☐ No
Heart Murmur .....☐ Yes ☐ No
Angina .....☐ Yes ☐ No
Frequently Tired.....☐ Yes ☐ No
Anemia .....☐ Yes ☐ No
Emphysema.....☐ Yes ☐ No
Cancer.....☐ Yes ☐ No
Arthritis .....☐ Yes ☐ No
Joint Replacement .....☐ Yes ☐ No
Hepatitis/Jaundice .....☐ Yes ☐ No
Sexually Transmitted Disease .☐ Yes ☐ No
Stomach Troubles/Ulcers ...☐ Yes ☐ No

Chest Pains .....☐ Yes ☐ No
Easily Winded.....☐ Yes ☐ No
Stroke .....☐ Yes ☐ No
Hay Fever/Allergies.....☐ Yes ☐ No
Tuberculosis .....☐ Yes ☐ No
Radiation Therapy .....☐ Yes ☐ No
Glaucoma .....☐ Yes ☐ No
Recent Weight Loss .....☐ Yes ☐ No
Liver Disease .....☐ Yes ☐ No
Heart Trouble.....☐ Yes ☐ No
Respiratory Problems.....☐ Yes ☐ No
Mitral Valve Prolapse.....☐ Yes ☐ No
Other.....☐ Yes ☐ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information necessary to secure payment of benefits. I understand it is my responsibility to advise the dental staff of all medical changes that occur between dental appointments.

Date _____ Signature _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ (name of Ins. Co.(s)) and assign directly to **Ivanhoe Dental Group Ltd.** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date _____ Signature _____

MINOR / CHILD CONSENT

I, being the parent or guardian of _____ (name of child/minor) do hereby request and authorize the dental staff to perform necessary dental services for my child, including, but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered.

Date _____ Signature _____