Amy F. Temple
Family Dentistry D.D.S., P.A.

Patient Information & Consent

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

Date of Birth: _____ **Male**____ **Female**___ **Married**__ **Single**___ **Child**___ **Other**____

Phone # for Reminder Call: _____ **Cell # for TEXT Reminder: _____**

Email Address for Reminder: _____ Other Phone_____

Address: _____
(Street) (City) (State) (Zip)
Date of Last Dental Visit: _____ **Social Security Number**: _____

If you have ever had heart bypass/stint placed, heart valve surgery, cancer treatments or had an artificial joint placed, you may need written notification from your medical doctor whether or not you can have treatment and if antibiotic premedication is required. ***Are you currently taking a premed? Yes ____ No ____**
Name of drug: _____

-Do your gums bleed while brushing/flossing? YES ____ NO ____
-Are your teeth sensitive to any of the following liquids/foods? HOT ____ COLD ____ SWEET ____ SOUR____
-Do you have any sores or lumps in or near your mouth? YES ____ NO ____
-Have you experienced any of the following problems in your jaw? CLICKING _____ PAIN _____
DIFFICULT TO OPEN/CLOSE _____
-Have you ever had any complications following dental treatment? YES ____ NO ____
-If yes, please explain: _____

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: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

NEXT

Dental Insurance Information

Primary Insurance

Name of Insured **Employee**: _____
Last First MI

Is insured employee a patient? ☐ Yes ☐ No SS # _____

Insured's Birth Date: _____ Subscriber ID# _____ Group #:_____

Insured's Address: _____
Street City
State Zip Code
Insured's Employer Name: _____

Employer Phone Number: _____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge and the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Amy F. Temple, DDS, PA (the Practice), to take radiographs, photographs, or study models, and to use any other diagnostic aids deemed appropriate for accurate diagnosis of the patient's dental needs. I also authorize the Practice to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. Further, I understand the responsibility of payment for dental services provided to my dependents and myself is due and payable at the time service is rendered. Having received and/or review the Notice of Privacy Practices, I authorize the use and disclosure of this information for the purposes of treatment, payment, dental care, and referral.

I grant my permission to you or your assignee, to telephone and text me at all provided numbers and by email to discuss matters related to this form, appointments and/or accounting,

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

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

NEXT

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