ACME CARE
Medical Clinic

ACME CARE Medical Clinic
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Detailed Medical Consent

PERSONAL INFORMATION

Patient Name

Patient Birth Date

Patient Gender

Patient E-Mail

Occupation

Address

Work Phone

Cell Phone

Are you a full-time student at a college?

If yes, name of college

Patient Age

Marital Status

ow did y hear abou ur office?

Nearest relative not living with you:

Name

Phone

Relationship

Address

Do you have a personal physician?

Physician's Name

Address

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Physician's Phone

Date of Last Visit

Are you currently under the care of a physician?

Do you have any artificial joints or implants?

Are you taking any medication? If yes, please list each one

Do you have any allergies?

If yes, please list

If Female, do you have any of these conditions?

If you are pregnant, how many weeks?

Do you have any disease, condition or problem that you feel we should know about? If so, please describe

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Dental History

How may we help you today?

Your current dental health is

Please answer the following

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Please answer the following

floss/week

brush/day

When was you last dental visit?

When was your last dental cleaning?

How can we accommodate you better during your dental visit?

Is there any specific service and/or concern you would like to inquire about?

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I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Responsible Health Professional, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurances. I hereby authorize the doctor to release all information necessary to secure the payments of benefits.

I authorize the use of this signature on all insurance submissions.

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I understand that the information I have given today is correct to the best of my knowledge.

I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand that if the patient is a minor, _____ parent or legal guardian needs to sign this form.

Name of the Patient

Name of the Parent or Legal Guardian (if applicable)

Date

Date

Signature

Signature

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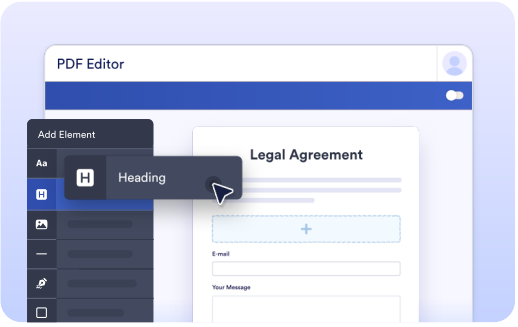

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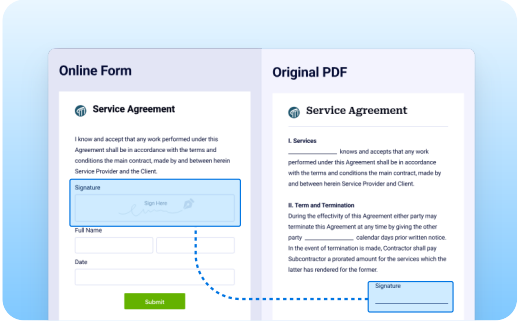

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