First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____Responsible Party (if different than patient): _____

Patient Information:

Address: _____ City: _____

State: _____ Zip: _____

Phone (Home): _____ Work: _____ Cell: _____

Email: _____

Would you like to receive appointment confirmations via Email or Text? _____

Sex: Male or Female Birth Date: _____ Age: _____ Marital Status: _____

Social Security Number: _____

Dental Insurance Information:

Policy Holder: _____ Relationship to Patient: _____

DOB Policy Holder: _____Employer: _____

Insurance ID: _____ Group ID: _____

Insurance Claims Address: _____

We file insurance as a courtesy to the patient. Dr. Munz does not participate with any insurance plan. You **must** provide the above information in full, or a copy of your dental insurance card. Payments from the insurance company will go directly to the policy holder. Payment for services rendered are due the day of treatment unless otherwise arranged.

Medicare **ONLY: (Only continue this section if you have Medicare)**

I understand that Medicare does not cover any services rendered in Dr. Munz office. Therefore, I agree to a private pay agreement between myself, the patient and the provider, Dr. Raymond Munz.

Patient Signature: _____

General Information:

How did you hear about our practice? _____

Previous Dentist: _____ Last visit: _____

If you wear dentures currently, when was the last denture made? _____

Health problems that you may have, or medication that you may be taking could affect the type of dental treatment you will receive. Thank you for answering the following questions:

Are you under a physician's care now? Y or N If so, Why? _____

Have you ever been hospitalized or had a major operation? _____

Have you ever had a serious head or neck injury? _____

Are you taking any prescribed rnedications? OTC or herbal supplements? Please list or provide a list.

_____

Are you taking a prescribed Blood Thinner or Aspirin on a daily basis? _____

Do you use tobacco? Y or N Which type? _____

Do you take any mood-altering drugs other than what is listed? _____

Have you been instructed by a physician to take antibiotics before any dental treatment? Y or N

Have you ever had a joint replacement? Y or N If yes, when and which joint? _____

Women: Are you Pregnant? Y or N Nursing? Y or N Taking Oral Contraceptives? Y or N

Do you have or ever had any of the following conditions/problems. Please circle:

AIDS/HIV+ Alzheimer's Anemia/Blood Disorder Arthritis Cold Sore/Fever Blister

Diabetes Drug Addiction Emphysema/Breathing Epilepsy/Seizures Excessive Bleeding

Fainting Spells/Dizziness Fibromyalgia Frequent Cough Frequent Headaches Heart Attack/Failure

Hepatitis A, B, C High Blood Pressure Psychiatric Care Sinus Problems Stroke Thyroid Disease

Cancer: Type: _____ When: _____ Radiation or Chemotherapy? _____

Osteoporosis: Type: _____ When: _____ Treatment? _____

Do you, or have you ever taken any of the following medications? Please circle:

St Johns Wort Kava Kava Tagament Prilosec/Nexium Cardizem Serazole Fosamax

Actonel Boniva Phen-Phen

BLOOD THINNER:

I understand that certain procedures require me to be off my blood thinner/aspirin. I understand it is my responsibility to contact my prescribing physician when discontinuing the use of my blood thinner and or Aspirin.

Signature: _____ Date: _____

Are you allergic to any of the following? Please circle or list.

Aspirin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Antibiotics: _____

Other: _____

Emergency Contact: _____

Phone Number: _____ Relationship to Patient: _____

SHARE INFORMATION:

I give permission to share my dental records/information to the following:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

FINANCIAL AGREEMENT:

In the event that your payment is returned to Dr. Munz office, there will be a $35 insufficient fund fee added to your amount owed. If not repaid within 10 days your account will be charged 1.5% interest per month (18%APR) from the date of service. If account is not paid and collection efforts are necessary, you will be responsible for all attorney fees (deemed to be 33%).

Patient Signature: _____

MISSED APPOINTMENT:

It is the patient, and/or guardian's responsibility to remember the allotted appointment. As a courtesy, we will notify by email, text and/or phone call. If you do not call our office 24 hours before the allotted appointment time to cancel or reschedule, there will be a $75 missed appointment fee charged. Please be courteous and make any changes to your appointments 24 hours ahead of time. Thank you!

Patient Signature: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my/patient's health. It is my responsibility to inform the office of any changes in medical status.

Signature: _____ Date: _____

Information Reviewed by : _____ (staff/provider initials)