FINANCIAL AGREEMENT

* For my convenience, Noble Smiles Dentistry may release my information to my insurance company, and receive payment directly from them.
* Every effort will be made to help me with my insurance, <u>but if they do not pay as expected, I will still be responsible</u>.
* If sent to collections, I agree to pay a $30 **collection fee**, all related fees and court costs.
* Treatment plans may change, and I will be responsible for the work actually done.
* I will pay a $15 fee for appointments broken without 24 hours notice.

Signature____ Date_______________________

MEDICAL HISTORY

Name of Medical Doctor:____ City/State___________________________

Emergency Contact__________________________ Phone_________________Relationship_____________________

* List all the medications or drugs you are now taking:

[ ] None
____
____
____
____

* Check medications or drugs you are allergic to:

[ ] None
[ ] Aspirin
[ ] Codeine/ Other Narcotics
[ ] Erythromycin
[ ] Latex Rubber
[ ] Local Anesthetics
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Other: ____________

Check any medical conditions you may have:

[ ] None
[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Anemia/Leukemia
[ ] Anorexia/Bulimia
[ ] Arthritis
[ ] Asthma/Hay Fever
[ ] Blood Clotting Problems
[ ] Blood Transfusion
[ ] Bronchitis
[ ] Cancer/Tumor or Growth
[ ] Cardiac Pacemaker
[ ] Chest Pain Upon Exertion
[ ] Damage Heart Valve
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting Spells/Seizures
[ ] Fever Blisters/Herpes
[ ] Frequent Headaches
[ ] Frequently Dry Mouth/Sjogren
[ ] Gall Bladder Trouble
[ ] Heart Attack/Stroke
[ ] Heart Disease/Angina
[ ] Heart Murmur
[ ] Hepatitis/Jaundice
[ ] High Blood Pressure
[ ] Hives/Skin Rash
[ ] Joint Replacement, Date of: ___________
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Problems
[ ] Mitral Valve Prolapse
[ ] Persistent Diarrhea
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Sexually Transmitted Disease
[ ] Sinus Trouble
[ ] Stomach Ulcers
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Other: ____

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? [ ] Yes / [ ] No

Tobacco use? If so, what kind and how much?____

Unusual reaction to dental injections?____

Reason for today's visit:____ Are you in pain? [ ] Yes __________ [ ] No

New patients:

Name of former dentist____ City/State_________________________

Date of last cleaning and exam______________________

By signing below, I certify that all of the above information is true to the best of my knowledge.

____ ________________________

Patient/Guardian Name (printed) Date

____

Patient/Guardian Signature