Dr. Thomas Watson & Dr. David Lampl
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Patient Information

Name: _____ Date:_____
Last First MI
Birthdate:_____Social Security #:_____

Address: _____
Street Apartment#

_____
City State Zipcode
Home Phone:_____Cell Phone:_____Work Phone:_____Ext:___

Email:_____Order of preference for contact:_____
Gender: ☐ Male ☐ Female
Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Health History

Are you pregnant?_____Due date:_____
Please circle all of the following that have ever applied to you:

☐ AIDS or HIV
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Emphysema
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ A ☐ B ☐ C
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitrial Valve Prolapse
☐ Nervous Disorders
☐ Pace Maker
☐ Radiation Treatment
☐ Respiratory Issues
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Issues
☐ Stomach Issues
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Latex Allergy
☐ Penicillin Allergy
Other:☐ _____

Reason for this visit:_____
Have you ever had any complications following dental treatment?
If yes, please explain:_____☐ yes ☐ no
Are you currently under the care of a medical physician?
If yes, please explain:_____☐ yes ☐ no
Please list any medications you are currently taking:_____
Who may we thank for referring you?_____

Dental Insurance Information

Insurance Plan:_____ID#:_____Group name and #:_____
Name of insured:_____Birth date:_____Patient?_____
Insured's address_____
Insured's Employer_____
Patient's relationship to insured:
Secondary Dental Insurance: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insurance Plan:_____ID#:_____Group name and #:_____
Name of insured:_____Birth date:_____Patient?_____
Insured's address_____
Insured's Employer_____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If a change in my health occurs, I will inform the doctors at my next appointment.

Signature (patient, parent or guardian):_____**Date:**_____

Consent for services

As a condition of your treatment by this office, financial agreements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial agreements, must be paid for in cash at the time of service.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office can not render services on the assumption that our charges will be paid by an insurance company.
I hereby authorize any provider, insurer or organization to release any information regarding dental history, treatment or benefits payable for claims to plan administrators or the authorized agent for purposes of determining benefits payable.
I hereby authorize payment directly to the Dentist for the dental benefits otherwise payable to me.
A service charge of 1.5% per month (18% per annul) on the unpaid balance will be charged on all account exceeding 60 days , unless previously written financial arrangements are satisfied.
I understand that the fee estimate listed for this dental care can only be extended for a period of 6 months from the date of patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor or his assignees at the time said services are rendered, or within 5 days of billing if credit should be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing within the time of payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney or court fees if should be rendered hereunder.
I grant my permission to you or your assignees to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.
Signature (patient, parent or guardian):_____Date:_____

Signature (guarantor of payment/responsible party)_____Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I _____, have received a copy of this office's Notice of Privacy Practices.

Signature (patient, parent or guardian)_____Date:_____

Contact Preferences

In an effort to become more efficient with our recall and appointment confirmation systems, we ask that you please indicate your preference of being reached in the following questionnaire. We will make every effort to comply with your wishes so we don't inconvenience you.

Please indicate order of contact preference. If you prefer we do not call one of these at all, please mark 'N'.
_____Home_____Cell_____Work

Is it ok to call to change your appointment to a better time if another appointment becomes available?
☐ yes ☐ no

We plan on adding a system to confirm appointments via email and text. Please indicate if it is ok to contact you either of these ways and list the contact info.
Email:_____Cell#:_____

Thank you!