George Lee, DDS

New Patient Form

805 497-1644

Full Name | Male ☐ Female ☑

Email Address | Married ☐ Single ☐ Child ☐ Other ☐

Social Security # | Birth Date

Home Phone | Work Phone | Mobile Phone

Preferred Appointment Times: Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐

Preferred Day: Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

Address: Street | Apartment #:

City | State | Zip Code

Health Information

Date Of Last Dental Visit: | Reason For Visit:

Have your ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy
  - Due date:
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

☐ Other: List all that may apply

New Patient Form: Health Information

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain:

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain:

Name of Physician: Phone:

Do you have any health problems that need further clarification? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct, If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Name: Date:

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend ☐ Another patient, relative ☐

Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice:

Spouse or Responsible Party Information

The following is for: the patient's spouse ☐ The person responsible for payment ☐

Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security # | Birth Date

Home Phone | Work Phone | Mobile Phone

Address: Street | Apartment #:

City | State | Zip Code

Employment Information

The following is for: the patient ☐ The person responsible for payment ☐

Employer Name | Occupation

Address: Street | City

State | Zip Code

Primary Insurance Information

Name Of Insured: Last, First | MI

Is Insured A Patient? Yes ☐ No ☐ | Insured's Birth Date | ID # | Group #

Insured's Address: Street | Apartment #

City | State | Zip Code

Insured's Employer Name

Address: Street | City | State | Zip Code

Patient's Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name

Address: Street | City | State | Zip Code

Secondary Insurance Information

Name Of Insured: Last, First | MI

Is Insured A Patient? Yes ☐ No ☐ | Insured's Birth Date | ID # | Group #

Insured's Address: Street | Apartment #

City | State | Zip Code

Insured's Employer Name

Address: Street | City | State | Zip Code

Patient's Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name

Address: Street | City | State | Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements 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 arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental service. This 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 cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the 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 is assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for 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 fees if suit instituted hereunder.

I grant my permision to you or your assignee to telephone me at my home or at my work to discuss matters related to this form.

Broken Appointment Fee – A $25.00 fee will be charged for a second broken appointment. This fee must be paid at the time of the next appointment.

I agree to the above terms: ☐

Name of Patient, Parent or Guardian	Date	Relationship to Patient

Print Submit