Chart #: «Chart»
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date: __________
Last, First MI (Preferred Name)
Gender: ____________ Family Status: ____________
Social Security #: ______________________ Birth Date: ______________________
Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________
Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S
Address: ______________________________
Street Apartment #
____
City State Zip Code

Health Information

Date of Last Dental Visit: ____________ Reason for this visit: ______________________
Physician: ______________________ Physician Phone Number: ______________________

Have you ever had any of the following? Please check those that apply. History Reviewed by:____________

- ☐ Asthma____________
- ☐ Respiratory Problems____________
- ☐ Sinus Problems____________
- ☐ Smoker, How Much______ How Long__________
- ☐ Rheumatoid Arthritis____________
- ☐ Arthritis____________
- ☐ Artificial Joints____________
- ☐ Chest Pain____________
- ☐ Stroke____________
- ☐ Heart Disease____________
- ☐ Thyroid Hypo/Hyper____________
- ☐ High B.P. / Low B.P.____________
- ☐ Pacemaker____________
- ☐ Mononucleosis____________
- ☐ Tuberculosis____________
- ☐ AIDS____________
- ☐ STD's____________
- ☐ Hepatitis / Jaundice____________
- ☐ Liver Disease____________
- ☐ Kidney Disease____________
- ☐ Diabetes____________
- ☐ Cholesterol____________
- ☐ Glaucoma____________
- ☐ Blood Thinners____________
- ☐ Excess Bleeding____________
- ☐ Dizziness / Fainting____________
- ☐ Epilepsy____________
- ☐ Problems Swallowing____________
- ☐ Hoarseness____________
- ☐ Osteoporosis ____________
- ☐ Cancer ____________
- ☐ Radiation Treatment____________
- ☐ Chemotherapy____________
- ☐ Ulcers / GERD____________
- ☐ Eating Disorder____________
- ☐ Pregnancy____________
  Due Date:__________

☐ Allergies______________________________
___ Codeine ___Penicillin ___Latex ___Metal
☐ Present Medications:______________________________
____
____

- Have you ever had any complications following dental treatment or with local anesthetic? ____________
  ____
- Have you been admitted to the hospital or needed emergency care during the past two years? __________
  ____
- If you could, would you change anything about your smile? ______If so, what?____________________
  ____

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.

______________________________ Date: ____________
Signature of patient, parent or guardian

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: ______________________________

L. Michael Gouveia, D.M.D
Lisa Carvalho, D.M.D.
499 Rockdale Ave.
New Bedford, MA. 02740
508-992-4608

Patient Name: ______________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements are made in advance, since the practice depends upon reimbursement from the patients for the costs incurred in their care.

All emergency dental services and any dental services performed without previous financial arrangements must be paid at the time services are performed.

Patients who carry dental insurance understand that they are personally responsible for payment of all dental services. This office will help prepare the patients insurance forms, assist in making collections from insurance companies and will credit any such collections to the patient's account. Our dental office cannot render services based on the assumption that our charges will be paid by an insurance company and the patient bears all responsibility for understanding their coverage limitations. Final responsibility for the payment rests with the patient.

A service charge of 1½% per month (18% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate quoted for dental care will only be extended for a period of six months from the date of the estimate.

In consideration for the professional services rendered to me, I hereby agree to pay for all services to Dr. L. Michael Gouveia, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit has been extended. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder for nonpayment of balance due.

I grant my permission to Dr. Gouveia or his assignee, 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.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Signature of patient, parent or guardian (Responsible party) Date

____
Relationship to patient