PATIENT INFORMATION

Today's Date _____/_____/_____ E-Mail_____SS#_____-_____-_____

Name: _____ Preferred Name: _____
Last First MI

Birth Date: _____/_____/_____ **Ok to Text:** ___ **yes** ___**no** _____**Male** _____**Female**

Home Address: _____
Street City State Zip Own or Rent

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

Employer:

_____
Name

_____
Occupation How Long

Status: _____Minor _____Married _____Divorced _____Single _____Widowed

Please tell us who referred you to us_____
(TV, Facebook, Friends, Family etc...)

ACCOUNT INFORMATION

Person ultimately responsible for account

Name: _____ **Relationship**_____ **Phone#: (_____)** _____

Billing Address:

_____

SS#: _____/_____/_____ DOB: ____/____/____ **Payment Method:** _____Cash _____Check _____Credit Card

Dr's License **#**_____**Credit Card #**_____ Exp: ____/_____ Sec. Code: _____

INSURANCE INFORMATION

Primary Dental Insurance Company (Please provide card)
Name: _____ **Group #** _____

_____ **Insured's ID #**_____
Address
Phone #: (_____) _____ **SS#** _____ **-** _____ **-** _____

Insured's Name: _____ Relationship: _____DOB____/____/____

Insured's Employer: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. **Secondary insurance accepted.**

SIGNATURE: _____ _____/_____/_____
Date

Emergency Information

In the event of an Emergency we should contact? _____

Home Phone # (_____) _____Work # (_____) _____Cell# (_____)_____

Relationship: _____ MD: _____Phone# (_____) _____

PLEASE CONTINUE ON BACK

MEDICAL HISTORY

Please list any medications you are currently taking:

_____

_____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures?
Please circle Yes or No

Y N Heart Attack / Stroke
Y N Heart Surg./Pacemaker
Y N **Heart Mur-Mur**
Y N Rheumatic Fever
Y N **Mitral Valve Prolapse**
Y N Artificial Valves
Y N Heart Disease
Y N Congenital Heart Disease
Y N Chest Pains
Y N Scarlet Fever
Y N High or Low Blood Pressure
Y N Thyroid Problems
Y N Kidney Problems
Y N Liver Problems
Y N Respiratory Problems
Y N Sinus Problems
Y N Stomach Problems/Ulcers
Y N Psychiatric Problems
Y N Venereal Disease
Y N Alcohol/Drug Abuse
Y N Tuberculosis
Y N Jaw Problems TMJ/TMD
Y N Cancer/Tumors
Y N Shingles
Y N Hepatitis
Y N HIV + AIDS/ARC
Y N Arthritis/Rheumatism
Y N **Artificial Bones/Joints**
Y N Emphysema
Y N Fainting/Seizures/Epilepsy
Y N Severe/Frequent Headaches
Y N Frequent Neck Pain
Y N Back Problems
Y N Cosmetic Surgery
Y N Xray or Cobalt tmt.
Y N Chemotherapy
Y N Asthma
Y N Difficulty Breathing
Y N Diabetes/Hypoglycemia
Y N Leukemia
Y N Anemia
Y N Nervousness
Y N Bleeding Problems
Y N Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you aware of having an **allergic (or adverse reaction)** to any medication or substance? **Yes** ____ **NO** ____ Please list: _____

_____

Do you use tobacco? ____No ____Yes/How used? _____ How much? _____ How Long? _____
Do you wear contact lenses? _____ Yes _____ No
For Women: Are you taking Birth Control Pills? _____ Yes ____ No Are you Pregnant? ____ No ____ Yes/How long? _____ Are you nursing? _____ Yes _____ No

DENTAL INFORMATION

Reason for today's visit: _____Exam _____Emergency _____Consultation

Are you required to pre-medicate with antibiotics prior to treatment? ____Yes ____ No ____ Don't know

Previous Dentist: _____(____)_____
Name Phone #
Last dental exam: ____/____/____ Last dental X-rays: ____/____/____ Times a day you brush? _____
Times a week you floss? _____

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was competed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I understand I will be charged for appointments cancelled less than 24 hours in advance. Verbal confirmation for NEW PATIENTS is required 2 days prior Appointments, non-confirmation result in cancelation of appointment.

Signature: _____ **Date** ____/____/____

_____Adult Patient _____Parent or Guardian _____Spouse

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