WELCOME TO OUR OFFICE

Thank you for filling out this form accurately and completely. The information you provide will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help!

PATIENT INFORMATION

*Name*____*Male*____*Female*____
*Minor*______ *Single*______*Married*______ *Divorced*______ *Separated*______*Widowed*________
*Mailing Address*_________________________________*City,ST*________________ *Zip*________
*Birthdate*_____________ *E-Mail Address*____
*SS#*_______________________*Home Ph#*__________________*Cell#*_____________________
*Employer*____*Occupation*_____________
*Business Street Address*__________________________*City*_________________ *Zip*_________
*How Long at this job?*_______________________ *Wk Phone*______________________________
***Children Only**:School*______________________________*Grade*_________________________

SPOUSE INFORMATION

*Name*____ *Occupation*_________________________
*Employer*____________________________________*Wk Phone*__________________________
*Business Street Address*________________________ *City*________________*Zip*____________

RESPONSIBLE PARTY

*Person Responsible for Payment*____
*Relationship to Patient*__________________________ ___*Phone*___________________________
*Street Address*_________________________________*City*___________________*Zip*__________
Business Address _______________________________*Wk Phone*_________________________

INSURANCE INFORMATION

*Name of Insured*____
*Relationship to Patient*____________________*Soc Sec # of Insured*_______________________
*Birthdate of Insured*________________________*Group#* ______________________________
*Insurance Co*________________________________*Employer*____________________________

If more than one insurance company, please complete the following:
*Name of Insured*____
*Relationship to Patient*____________________*Soc Sec # of Insured*_______________________
*Birthdate of Insured*________________________*Group#*_______________________________
*Insurance Co*____________________________*Employer*_______________________________

GETTING TO KNOW YOU

Is another member of your family or relative a patient in our office?
*Name*_____________________________________*Relationship*____________________________
*Referred to Us By*____
*Person to Contact for Emergency*______________________________*Phone#*________________
*Former Dentist*__________________________________*Last Appt*_________________________
*Medical Doctor*____
*Is there anything about the appearance of your teeth that you don't like?(color,shape, size, spaces,cracks, chips, alignment, other*____

HEALTH HISTORY

PLEASE CIRCLE YES OR NO

Yes No Are you currently taking ANY medications? If so, please list:

____

Yes No Are you allergic to penicillin, aspirin, or codeine? **(Circle applicable ones)**
Yes No Are you allergic to any other drugs or medication? **List** __________________________
Yes No Have antiresorptive drugs (Fosamax,Boniva, Zometa, etc) been given in the past five years?
Yes No Are you under treatment of a medical doctor? If so, state reason:
____
Yes No Do you smoke or chew tobacco?
Yes No Have you ever had excess bleeding requiring treatment?
Yes No Are you currently bleaching your teeth?

WOMEN **PLEASE CIRCLE YES OR NO**

Yes No Is there a possibility you may be pregnant?
Yes No Are you nursing?
Yes No Are you taking birth control pills?

NOTE: *Antibiotics (such as penicillin, erythromycin, etc.) and some medications may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.*

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

Yes No Heart Disease or Attack
Yes No Stroke
Yes No Artificial Heart Valve
Yes No Heart Pacemaker
Yes No Angina or Chest Pain
Yes No High/Low Blood Pressure
Yes No Hemophilia
Yes No Kidney Trouble
Yes No Dialysis
*Yes No Hepatitis **(Type___________)***
Yes No Cortisone Medicine
Yes No Pain in Jaw Joints
Yes No Sexually Transmitted Disease
Yes No Immune System Problems r
Yes No Epilepsy or Convulsions
Yes No Fainting or Dizzy Spells
Yes No Ulcers
Yes No Asthma/Hayfever/Emphysema
Yes No Sinus Trouble
*Yes No Diabetes **(TYPE __________)***
Yes No Artificial Joints
Yes No Cancer
Yes No Chemotherapy/Radiation

FEES AND PAYMENTS

We make every effort to keep down the cost of your dental care. You can help by paying upon completion of each visit (Cash, Check, Credit Card, or CareCredit-a special dental credit card.) An ESTIMATE of the charge for any procedure can be given to you.

Please remember that insurance is filed as a courtesy to our patients. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge***. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE COMPANY.*** If the patient's portion of the dental bill is not paid within 25 days of the monthly billing date, a late charge of 0.5% per month will be assessed.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me.

Signature____**Date**___________