

WELCOME... Thank You For Selecting Our Dental Team

Date _____

Patient Name _____ Nickname _____
Last First MI

Birth date ____/____/____ Age _____ Gender _____ Social Security _____

Home Address _____
Street City State Zip

Home Phone () _____ Work () _____ Cell () _____

Employer _____ Address _____

Driver's License _____ Other family members seen by us _____

Whom may we thank for referring you? _____

SPOUSE / PARENT / GUARDIAN INFORMATION

His/Her Name _____ Birth date ____/____/____ Social Security _____

Employer _____ Home () _____ Driver's License _____

EMERGENCY CONTACT NOT LIVING WITH YOU

Name _____ Relation _____ Home () _____

Home Address _____
*Street City State Zip***INSURANCE INFORMATION****Primary Insurance** _____ Phone () _____ Group _____Insurance Co. Address _____
PO Box/ Street City State Zip

Insured's Name _____ Insured Social _____ Birth date ____/____/____

Insured's Employer _____ Employer Address _____

Secondary Insurance _____ Phone () _____ Group _____Insurance Co. Address _____
PO Box/ Street City State Zip

Insured's Name _____ Insured Social _____ Birth date ____/____/____

Insured's Employer _____ Employer Address _____

APPOINTMENTS: Our office understands how valuable your time is. We strive to have our patients seen on time. We accommodate your schedule as much as possible when making appointments. Valuable clinical time is lost when appointments are missed or cancelled with short notice (*less than 24 hours*). You will be charged \$50.00 per appointment for no show or short notice cancellations.

IF YOU HAVE DENTAL INSURANCE: Dental insurance policies are very different. Most require an annual deductible. We will give you an approximate dollar amount of your portion owing after insurance. Your portion of uncovered expenses are due at time of your appointment. We cannot guarantee insurance payment. You will be billed for total treatment charges for insurance non-payment which is 90 days past due.

IF YOU DO NOT HAVE DENTAL INSURANCE: Payment is required at the time dental services are performed. You are financially responsible for the services you receive.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES

Signature _____ Date ____/____/____

Medical Information

Please answer each question. Check yes or no. If in doubt, leave blank.

Name: First _____ Middle _____ Last _____

Are you under the care of a physician?..... Yes No

If so, what is the condition? _____

Have you ever been hospitalized or had a serious injury?..... Yes No

If yes, explain. _____

Have you ever had excessive bleeding following an injury?..... Yes No

Do you smoke or use chew tobacco?..... Yes No

If yes, how much? _____

(Women) Are you pregnant? Due date?..... Yes No

Are you taking contraceptives (birth control pills) or hormones?..... Yes No

Are you ALLERGIC or have you ever experienced any reaction to the following?

Local Anesthetics (Novocaine)..... Yes No

Penicillin/Other Antibiotics?..... Yes No

Please identify type _____

Codiene..... Yes No

Asprin..... Yes No

List other allergies we need to be aware of _____

Please list any medications and dosages you are presently taking.

1. _____

2. _____

3. _____

Check any of the following which you have had or have at present.

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart diseases or attack | <input type="checkbox"/> Cancer/Leukemia/Radiation | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Hemophilia (Bleeding disorder) | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> A.I.D.S. (H.I.V. Positive) | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Fainting/Dizzy Spells |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Anemia | <input type="checkbox"/> Dieting Concerns |
| <input type="checkbox"/> Artificial Joints (Hip/Knee) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Respiratory/Asthma |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Eye Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcer/Gastric Reflux | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus Trouble/Hay Fever | <input type="checkbox"/> Snoring/Sleep Apnea |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 health practitioners.

Signature or Patient or parent if minor

Date

Doctors Signature

Date