WELCOME!!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you need assistance, we will be happy to help!

CONTACT INFORMATION

Today's Date _____

Name _____

Preferred Name _____

Birth Date _____ SS# _____

Address _____

City, St., Zip _____

Home Phone _____

Cell Phone _____

May we contact you at work regarding: scheduling, treatment or account information? ❑Yes ❑ No Work Phone _____

❑ **E-Mail** _____

❑ Minor (under 18) ❑ Male ❑ Female

❑ Single ❑ Married ❑ Divorced ❑ Widowed

❑ Patient's Employer _____

❑ Spouse or ❑ Parent's Name _____

SS# _____ Birth Date _____

Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency? _____

Address _____ **Phone Number** _____

Relationship to Patient _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name of person responsible for this account _____

Relationship to patient _____

Address _____

Home Phone _____ Work Phone _____

Social Security# _____ Birth Date _____

Employer/Address _____

Is this person currently a patient in our office ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE

Name of insured _____

Relationship to patient _____ Birth Date _____

Social Security # _____ Date Employed _____

Employer _____

Employer's Address _____

City, St., Zip _____

Insurance Company _____

Ins. Co. Phone _____

Ins. Co. Address _____

Group# _____ Union or Local# _____

**DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE?

❑ Yes ❑ No IF YES PLEASE GIVE INFO TO RECEPTIONIST.

AUTHORIZED RELEASE - TERMS AND CONDITIONS

I hereby authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

Should legal action be required to enforce payment of this contract, the signer(s) hereof agree to pay a reasonable attorney's fee and court costs incurred by the need of such action.

Finance/handling charges will be assessed on any unpaid balance after a 90 day period at the rate of 21% per month.

I hereby agree to permit the taking of photographs and x-rays relative to my oral condition deemed necessary in the interest of my case. I understand that all such photographs and x-rays will be used only for scientific or educational purposes.

This office depends upon reimbursement from the patients for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangments, must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by any insurance company.

Assignement of insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 60 days from the date of patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party on such preceding shall be entitled all costs incurred including reasonable attorney's fees. I grant my permission to you, or assigns, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions and agree to their consent.

Signed _____ Date _____

Continued on back...

Patients Dental Health

Previous Dentist _____ Last Visit _____

Reason for changing dentists: _____

Are you taking Fosamax or other drugs for Osteoporosis? ☐ Yes ☐ No Other: _____

Why have you come to see us today? (e.g. pain, checkup, etc.) _____

_____

What do you wish you could change about your smile? _____

_____

Physician Name: _____ Address: _____

Phone: _____

Patients Medical History

Do you have or have you had any of the following? *(Please circle Y for yes and N for no.)*

Y N Heart Disease / Heart Attack
Y N Heart Murmur / Mitral Valve Prolapse
Y N Stroke
Y N Congenital Heart Lesions
Y N Abnormal Blood Pressure/High/Low
Y N Anemia
Y N Prolonged Bleeding Disorder
Y N Tuberculosis or Lung Disease
Y N Asthma
Y N Hay Fever
Y N Sinus Trouble
Y N Epilepsy / Seizures
Y N Ulcers

Y N Liver Disease
Y N Hepatitis Type A/B/C
Y N Diabetes/Insulin Reistance
Y N Kidney Disease
Y N Infectious Mononucleosis ("Mono")
Y N Herpes
Y N Arthritis
Y N Cancer/Chemotherapy
Y N Radiation Therapy
Y N History of drug addiction
Y N AIDS
Y N Immune Suppressed Disorder
Y N Glaucoma

Y N Mental Disorder
Y N History of Emotional or Nervous Disorders
Y N Excessive Fatigue or Sleepiness
Y N Snoring

WOMEN:
Y N Are you or could you be pregnant or nursing?

Y N Implants/Artificial Joints: Hip-Knee _____ Other _____
Y N I smoke or use chewing tobacco. If yes, how much per day? _____ How many years? _____
Y N I usually take an antibiotic prior to dental treatment.
Y N I have had a major surgery. Year _____ Type of operation _____
Y N Year _____ Type of operation _____
Y N Do you have any other medical problem or history NOT listed on this form? _____

Are you allergic to any of the following?
(please circle Y for yes and N for no.)

Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Penicillin
Y N Codeine
Y N ☐ Latex, ☐ Metals, ☐ Plastics
Y N Local Anesthetics (Novocaine)
Y N Other Medications - Which ones? _____

_____

Please list all medications you are currently taking:

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____