

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 have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Soc. Sec. # _____
Date _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated Male Female
If Student, Name of School / College _____ City _____ State _____ Full Time Part Time
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SSN# _____
Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

PLEASE CHECK IF YOU HAVE HAD OR HAVE ANY OF THE FOLLOWING:

- AIDS OR HIV INFECTION
- HEART MURMUR
- MITRAL VALVE PROLAPSE
- RHEUMATIC FEVER
- JOINT REPLACEMENT OR IMPLANT
- HEPATITIS TYPE _____ DATE _____
- LATEX RUBBER
- TUBERCULOSIS
- CARDIAC PACEMAKER
- HEART ATTACK DATE _____
- HEART DISEASE
- STROKE
- ANGINA
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- DIABETES
- LIVER DISEASE
- KIDNEY DISEASE
- EPILEPSY
- FAINTING
- ASTHMA
- RESPIRATORY PROBLEMS
- CANCER
- EMPHYSEMA
- LEUKEMIA
- MS
- RADIATION THERAPY
- ARTHRITIS
- STOMACH TROUBLES/ULCERS
- THYROID
- SEXUALLY TRANSMITTED DISEASE
- MONO
- ALCOHOLISM/DRUG DEPENDENCY
- A.D.D./A.D.H.D.

PLEASE CHECK IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

- LOCAL ANESTHETIC
- PENICILLIN
- OTHER ANTIBIOTICS _____
- ASPRIN
- CODEINE
- METALS
- OTHER (PLEASE LIST):

LIST MEDICATIONS YOU ARE TAKING, INCLUDING NONPRESCRIPTION:

DO YOU TAKE ANY BLOOD THINNERS?

DO YOU USE TOBACCO? _____

DATE OF LAST DENTAL EXAM _____

PREVIOUS DENTIST _____

MEDICAL DOCTOR _____

Authorization and Release

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. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)