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 # _____
Soc. Sec. # _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
If Patient is a Student, Name of School/College _____ City _____ State _____
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 _____ Birthdate _____ Home Phone _____
Employer _____ Work Phone _____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Dental Insurance Information

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

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

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

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Are you allergic or have you had any reactions to the following?		
Local Anesthetics (e.g. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Aspirin	☐	☐
Other	☐	☐
7. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Kidney Diseases	☐	☐
Heart Attack	☐	☐	AIDS or HIV infection	☐	☐
Rheumatic Fever	☐	☐	Thyroid Problem	☐	☐
Fainting/Seizures	☐	☐	Heart Disease	☐	☐
Asthma	☐	☐	Cardiac Pacemaker	☐	☐
Low Blood Pressure	☐	☐	Heart Murmur	☐	☐
Epilepsy / Convulsions	☐	☐	Angina	☐	☐
Leukemia	☐	☐	Anemia	☐	☐
Diabetes	☐	☐	Emphysema	☐	☐
Cancer	☐	☐	Tuberculosis	☐	☐
Arthritis	☐	☐	Radiation Therapy	☐	☐
Joint Replacement or Implant	☐	☐	Glaucoma	☐	☐
Hepatitis / Jaundice	☐	☐	Recent Weight Loss	☐	☐
Sexually Transmitted Disease	☐	☐	Liver Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐	Heart Trouble	☐	☐
Chest Pains	☐	☐	Respiratory Problems	☐	☐
Stroke	☐	☐	Other	☐	☐
Hay Fever / Allergies	☐	☐	Other	☐	☐

Financial Arrangements:

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full at each appointment.

_____ Cash _____ Personal Check
_____ Credit Card ☐ VISA ☐ MasterCard ☐ Discover
_____ Approved credit application prior to treatment
_____ I wish to discuss financial arrangements prior to treatment.

Accounts 90 days delinquent will be charged 1.5% monthly (18% annually)

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. It is my responsibility to inform the dental office of any changes in my medical status.

I authorize the dentist to release my 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 payors 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 services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____
Signature of Patient or Parent of Minor