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)

Date _____

Soc. Sec. # _____

Home Phone _____

E-Mail _____

Name _____ Birthdate _____ Cell _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's Employer _____ Work Phone _____

Spouse's Name _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

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 _____

Birthdate _____ Is this person currently a patient in our office? ☐ Yes ☐ No

Employer _____ Work Phone _____ SS# _____

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

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

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

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 within the last year?	☐	☐
If yes, please explain _____		
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 controlled substances?	☐	☐
6. Do you have or have you had any of the following?	→	→

Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (eg. Lidocaine)	☐	☐
Penicillin	☐	☐
Other Antibiotics (please list) _____	☐	☐
Sulfa Drugs	☐	☐
Barbiturates/Sedatives	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐

	Yes	No		Yes	No		Yes	No
AIDS or HIV Infection	☐	☐	Fainting / Seizures	☐	☐	Radiation Therapy	☐	☐
Allergies	☐	☐	Hay Fever	☐	☐	Respiratory Problems	☐	☐
Anemia	☐	☐	Heart Problems	☐	☐	Sexually Transmitted Disease	☐	☐
Artificial Heart Valve	☐	☐	Hepatitis / Jaundice	☐	☐	Shunts	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Stomach Problems / Ulcers	☐	☐
Cancer	☐	☐	Joint Replacement	☐	☐	Stroke	☐	☐
Cardiac Pacemaker	☐	☐	Kidney Diseases	☐	☐	Taken Fen Phen or Redux	☐	☐
Congenital Heart Conditions	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Low Blood Pressure	☐	☐	Other _____	☐	☐
Epilepsy / Convulsions	☐	☐	Osteoporosis	☐	☐			

7. Women Only:
   a) Are you pregnant or think you may be pregnant? ☐ Yes ☐ No b) Are you nursing? ☐ Yes ☐ No
   c) Are you taking oral contraceptives? ☐ Yes ☐ No

Patient Dental History

Name of Previous Dentist and Location _____ *Date of Last Exam* _____

	Yes	No
1. Have you ever had a head, neck or jaw injury?	☐	☐
2. Have you had any orthodontic treatment?	☐	☐
3. Do you wear dentures or partial?	☐	☐
If yes, date of placement _____		
4. Have you ever had prolonged bleeding or difficulty with extractions?	☐	☐

5. Do you have any of the following Dental concerns?	Yes	No
Excessive Bleeding in your gums	☐	☐
Sensitivity in your teeth	☐	☐
Tooth Pain	☐	☐
Jaw Pain	☐	☐
Sores in your mouth	☐	☐
Frequent Headaches	☐	☐
Clenching or Grinding of Teeth	☐	☐

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 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.

X _____

Signature of patient (or parent if minor)

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services or where there is prepayment for additional services. In the event your account is past due, it may be turned over to a collection agency. If your account is not paid in full and this account is turned over to a collection agency and/or an attorney, then you agree to be responsible for all reasonable fees necessary for the collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorneys fees.

MISSED APPOINTMENT

There will be a $20 charge after missing your second appointment if you haven't given us 24 hours notice. After third missed appointment you must prepay for any future appointments.

A 3rd miss is a $30.00 charge and then you would only be allowed to come back if you pre-pay for your appointments