

About You

Name: _____ M F
Last First Mi

Preferred Name: _____ Single Married Other

Birthdate: ___/___/___ Age: ___ SSN: _____

Home Address: _____

Home: () _____ Cell: () _____

Work: () _____

Email: _____

Employer: _____ Occupation: _____

What is the best time to reach you? _____

Additional Information

Previous Dentist: _____

Date of last visit: _____

Whom may we thank for referring you?

In the event of an emergency, whom should we contact?

His/Her Name: _____

Home: () _____ Cell: () _____

Work: () _____

Insurance Information

Insurance Co. Name: _____

Insurance Co. Phone: () _____

Group #: _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____

Insured's ID # or SSN: _____

Secondary Insurance Co. name: _____

Dental History

Are you allergic to any of the following? Please circle.

Aspirin	Dental Anesthetics	Penicillin
Codeine	Erythromycin	Sulfa
Metals/Plastics	Latex	Other

List any other drug/material allergies:

Do you require antibiotics before dental treatment? Y N

What concerns brought you to the dentist today?

Are you currently in pain? Y N

Are your teeth sensitive? Y N

Do you now or have you ever experienced pain/discomfort
in your jaw joint (TMJ/TMD)? Y N

Have you ever had a serious/difficult problem associated
with any previous dental work? Y N

Office Policy

We reserve the right to charge a minimum of \$75 in order to cover expenses occurred during the allotted time for your appointment should you not show up for a scheduled appointment or your appointment is cancelled less than 24 hours ahead of your scheduled time here in our office.

We all thank you for your cooperation in this matter.

Initials

Medical History

Have you ever had any of the following diseases or medical problems? Please circle.

Abnormal Bleeding	Difficulty Breathing	Hepatitis	Tuberculosis (TB)
Artificial Bones/Joints/Valves	Glaucoma	High / Low Blood Pressure	Ulcers/Colitis
Blood Transfusion	Heart Attack/Stroke	HIV / AIDS	Venereal Disease
Cancer/Chemotherapy	Heart Murmur	Mitral Valve Prolapse	
Congenital Heart Defect	Heart Surgery/Pacemaker	Radiation Treatment	
Diabetes	Hemophilia	Rheumatic/Scarlet Fever	
Any other conditions not listed above: _____			

Are you currently under the care of a physician? Y (name of Dr.) _____ N

Are you taking any prescription, over-the-counter drugs or herbal supplements? Y N

Please list: _____

Do you smoke or use tobacco in any form? Y N

I, the undersigned, do hereby acknowledge that I have read, answered to the best of my knowledge, and understood all statements on this document:

- We keep a record of the dental/health care services we provide you. You may ask to see an receive a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- You may see your record or get more information about it by contacting our office.
- I acknowledge availability of a copy of the office Notice of Privacy Practices should I wish to receive one.
- I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
- This office offers Nitrous Oxide (Laughing gas) to our patients for \$70. Most insurances do NOT pay for this option and payment is due at time of use.
- This office accepts most insurances but this does NOT guarantee payment of coverage from insurance companies.
- Payment is due at or before time of service. Financial options are available.
- I agree to pay interest at the rate of 1% per month (minimum of \$1) on my account balance, which remains unpaid 30days, or more after the date I am first billed.
- I understand that I am responsible for payment of services rendered and also responsible for any co-payments and deductibles that my insurance (if any) does not cover. This office strives to estimate accurately but I acknowledge that this IS only an estimate and my final bill will be determined by final process by my insurance company.
- I understand that I am responsible for all costs of dental treatment.
- I hereby authorize any release of information, including diagnosis and records of treatment or examination rendered, to my insurance company.
- I understand that if I do not pay my bill I will be sent to collections. I agree to pay all costs of collection including a reasonable attorney's fee if this account is referred to a collection agency.

Signature of Patient or Guardian

Date