



Welcome

PATIENT INFORMATION

First Name: _____ M.I. _____ Last Name: _____ Preferred Name: _____
 Sex: F M Date of Birth: _____ Soc. Sec.# _____ Driver's Lic.# _____
 Email: _____
 Address _____ City: _____ State: _____ Zip: _____
 Hm # (_____) - _____ Wk # (_____) - _____ Ext. _____ Cell (_____) - _____
 Patient/Parent Employer _____
 Present Position: _____ How long held: _____
 Referred by: Phonebook Website Location Patient Other _____
 In case of emergency who should be notified? _____ Phone: _____

METHOD OF PAYMENT: Payment in full or estimated insurance co-payment is to be paid in full at each appointment.

I will pay today's charges in full by: Cash Check Credit Card Other Financing

*ALL UNPAID CHARGES WILL BE SUBJECT TO FINANCE CAHRGES, ADMINISTATION FEES AND LEGAL COSTS INCURRED DURING COLLECTIONS

Who will be responsible for the account? Self Spouse Father Mother Other _____

Name: _____ Soc. Sec. # _____ D.L.# _____
 Hm Tel.# (_____) - _____ Cell # (_____) - _____
 Address: _____ City: _____ State: _____ Zip _____
 Employer: _____ Tel.:(_____) - _____

Insurance Information

Patient: Married Divorced Widowed Single Child

Insurance Information

Dental Insurance- 1st Coverage

Employee Name _____
 Employee Date of Birth _____
 Name of Insurance Co. _____
 Address _____
 Telephone _____
 Program or policy # _____
 Group # _____

Dental Insurance- 2nd Coverage

Employee Name _____
 Employee Date of Birth _____
 Name of Insurance Co. _____
 Address _____
 Telephone _____
 Program or policy # _____
 Group # _____

Smile Evaluation

Do you have specific dental problems? Y__N__
 If yes, please explain _____
 Do you have dental examinations on routine basis Y__N__
 Do you brush and floss daily? Y__N__
 Do your gums ever bleed? Y__N__
 Do you like the appearance of your teeth? Y__N__
 Are your teeth all in alignment (straight)? Y__N__
 Do you have spaces you don't like? Y__N__
 Do you like the color of your teeth? Y__N__
 Are there old fillings or dental work you don't like looking at? Y__N__
 Do you ever have clicking/popping/discomfort in the jaw joint? Y__N__
 Do you clinch or grind your teeth? Y__N__
 Have your past dental experiences been positive? Y__N__
 Do you smoke or chew? Y__N__
 Name of previous dentist: _____
 When was the last time you had a full mouth series of x-rays taken? _____

Medical information

Reason for today's office visit:

Name of your Physician:

Phone: _____

Have you had any illness, operation or been hospitalized in the past five years?

Are you taking any medication? ___Y___N

Please List

Are you allergic to any medications or substances?

- Latex Penicillin Codeine Sulfa
 Aspirin Acrylic Metal
 Other _____

Women

Pregnant/trying to get pregnant Y N

Nursing Y N

Taking oral contraceptives Y N

Health History

Heart Trouble/Disease	Yes	No	Irregular Heart Beat	Yes	No
Angina/ Chest Pain	Yes	No	Heart Attack/ Failure	Yes	No
Congenital Heart Disorder	Yes	No	Mitral Valve Prolapse	Yes	No
Heart Murmur	Yes	No	Anemia	Yes	No
Scarlet Fever	Yes	No	Artificial Heart Valve	Yes	No
Heart Pace Maker	Yes	No	Heart Surgery	Yes	No
High Blood Pressure	Yes	No	Blood Disease	Yes	No
Tuberculosis	Yes	No	Diabetes	Yes	No
Epilepsy/ Seizure	Yes	No	Asthma	Yes	No
Rheumatic Fever	Yes	No	Artificial joint, prosthesis	Yes	No
Shortness of Breath	Yes	No	Sickle Cell Disease	Yes	No
Leukemia	Yes	No	Recent Blood Transfusion	Yes	No
Chemotherapy	Yes	No	Lung Disease	Yes	No
Emphysema	Yes	No	Cancer	Yes	No
Ulcers	Yes	No	Excessive Thirst	Yes	No
Liver Disease	Yes	No	Hepatitis A (infectious)	Yes	No
Hepatitis B or C	Yes	No	Pain in Jaw Joints	Yes	No
Cortisone Medicine	Yes	No	AIDS	Yes	No
HIV Positive	Yes	No	Drug Addiction/Alcoholism	Yes	No
Kidney Problems	Yes	No	Renal Dialysis	Yes	No
Thyroid Disease	Yes	No	Stroke	Yes	No
Cold Sores/Fever Blisters	Yes	No	Fainting or Dizziness	Yes	No
Tumors or Growths	Yes	No	Nervousness	Yes	No
Psychiatric Care	Yes	No	Alzheimer's Disease	Yes	No
Allergies (Medicines)	Yes	No	Allergies (Pollen/Dust)	Yes	No
Need Premedication?	Yes	No			

Have you ever had any serious illness not listed above?

Do you wish to talk to the dentist privately about anything?

I **Certify** that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member if his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient:

(Parent or Guardian if minor)

X

Date:

Fees & Payment

We make every effort to keep down the cost of your dental treatment. You can help by paying upon completion of each visit. An estimate of the charge for any procedure you may require will be given to you upon request. If you have dental insurance we will be glad to fill out the proper forms and file them, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys' fees, and court costs.**

Signature of Patient:

(Parent or Guardian if minor)

X

Date:

Authorization

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient:

(Parent or Guardian if minor)

X

Date:

I **hereby acknowledge** that I have received a copy of this practice's **Notice of Privacy Practices**. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient:

(Parent or Guardian if minor)

X

Date