PLEASE PROVIDE YOUR INSURANCE CARD
AND PHOTO ID FOR OUR RECORDS

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phones (Home): _____ (Work): _____ Ext: _____ (cell)_____

Which # is best to reach you during the day?_____email_____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency contact name_____phone_____relationship_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work

☐ Another patient, friend_____ ☐ Another patient, relative_____

☐ Other _____

Dental History

How long since you have seen a dentist? _____
Last Complete Exam, Date: _____
Last Full Mouth X-Rays, Date: _____
Are you having PROBLEMS now?
Describe the problem: _____
How is your PRESENT dental health? POOR FAIR GOOD

Do you REGULARLY use DENTAL FLOSS?	YES	NO
Are you apprehensive about dental treatment?	YES	NO
Do you use cigars/cigarettes, pipe or chewing tobacco?	YES	NO
If YES, which one? _____		
Do you wear PARTIAL DENTURES?	YES	NO
Do you wear FULL DENTURES?	YES	NO
Are you UNHAPPY with your dentures?	YES	NO
Would you like to know more about PERMANENT REPLACEMENTS?	YES	NO
Have you ever had any PERIODONTAL treatments?	YES	NO
Do your gums BLEED, or feel TENDER or IRRITATED?	YES	NO
Are your teeth SENSITIVE to HOT, COLD, SWEETS, or PRESSURE?	YES	NO
If YES, which one? _____		
Are you UNHAPPY with the APPEARANCE of your teeth?	YES	NO
Do you have DISCOLORED teeth that bother you?	YES	NO
Would you like your smile to LOOK BETTER or DIFFERENT?	YES	NO
Are you aware of GRINDING or CLENCHING your teeth?	YES	NO
Do you have HEADACHES, EARACHES, or NECK PAINS?	YES	NO
IF YES, which one?_____		
Do you have pain in your jaw joints?	YES	NO

Health History

Do you have any CURRENT HEALTH PROBLEMS?	YES	NO
Describe: _____		
Are you under a PHYSICIAN'S CARE now?	YES	NO
For what? _____		
What medications are you currently taking?		
_____		
Are you pregnant?	YES	NO
Due Date? _____		

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	High Blood Pressure
Heart Murmur	Mitral Valve Prolapse
Artificial Heart Valve	Pacemaker
Artificial Joints	Hemophilia
Anemia	AIDS/ARC/HIV
Hepatitis A (infectious)	Stroke
Liver Disease	Fever Blisters
Diabetes	Epilepsy
Hepatitis B (serum)	Hepatitis C
Addiction	Chemotherapy
Radiation Treatment	Heart Surgery

ARE YOU ALLERGIC TO, OR HAVE YOU ADVERSELY REACTED TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic
Erythromycin	Latex
Nitrous Oxide	Codeine
Penicillin	

Are you aware of being allergic to any other medications or substances?

Please list:_____

PHYSICIAN_____PHONE#_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

**********************CONSENT***********************

The undersigned hereby authorizes the Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. The information given today is correct to the best of my knowledge, and I understand that it will be held in the strictest confidence.

If I have insurance, I understand that dental insurance is a contract between the insurance carrier and myself, and not between the insurance carrier and the Doctor. All charges are made directly to the patient and I am ultimately responsible for all dental fees regardless of insurance determinations. I assign any insurance benefits to be paid to the doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have already paid the dental fees incurred.

I am aware that all fees are due at the time services are rendered. In consideration of professional services rendered, or to be rendered, I agree to be financially responsible for all charges (at the Doctor's usual and customary fee) and for any expense the Doctor may incur in collecting these fees, including collection agency fees and/or ATTORNEY FEES. Any balance over 60 days past due automatically accrues a finance charge of 18% APR. A fee may also be assessed for any appointments that are cancelled without 24 hour notice.

PATIENT Signature (or Parent if patient is under 18 years old): _____ DATE: _____

DENTIST Signature: _____ DATE: _____