



Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

OFFICE USE ONLY: Patient# SS#

Date:

PATIENT INFORMATION

Name: Birthdate: Home Phone: Street Address: City: State: Zip: Sex: Status: E-mail: Mobile Phone: Employer/School: Employer Phone: Employer Address: City: State: Zip: Spouse/Partner/Parent's Name: Employer: Employer Phone: Whom may we thank for referring you? Person to contact in case of emergency: Phone:

RESPONSIBLE PARTY

Responsible Party Account Name: Relation to Patient: Street Address: City: State: Zip: Driver's License#: Birthdate: Bank: Employer: Work Phone: Currently a patient in our office? YES NO E-mail: Mobile Phone:

INSURANCE INFORMATION

Name of Insured: Relation to Patient: Birthdate: Social Security#: Date Employed: Employer: Employer Phone: Employer Address: City: State: Zip: Insurance Company: Group#: Union Local#: Insurance Address: City: State: Zip: How much is your deductible? How much have you used? Max. Annual Benefit:

## ADDITIONAL INSURANCE

Name of Insured: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Social Security#: \_\_\_\_\_ Date Employed: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group#: \_\_\_\_\_ Union Local#: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit: \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit: \_\_\_\_\_ Date of last dental care: \_\_\_\_\_  
Former Dentist: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_  
Dentist Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Please check if you have had problems with any of the following:  Bad Breath  Bleeding Gums  Clicking or Popping Jaw  
 Food collection between the teeth  Grinding Teeth  Periodontal treatment  Loose teeth or broken fillings  
 Sores or growth in your mouth Sensitivity to any of the following:  Cold  Hot  Sweets  When biting  
How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of pentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine):  YES  NO  
Have you had any serious illness or operations?  YES  NO If yes, describe: \_\_\_\_\_  
Have you ever had a blood transfusion?  YES  NO If yes, give approximate date: \_\_\_\_\_  
(Women) Are you pregnant?  YES  NO Nursing?  YES  NO Taking birth control pills?  YES  NO  
Please check if you have had any of the following:  
 Anemia  Chemotherapy  Headaches  Liver Disease  Swelling of Feet or Ankles  
 Arthritis, Rheumatism  Circulatory Problems  Heart Murmur  Mitral Valve Prolapse  Thyroid Problems  
 Artificial Heart Valves  Congenital Heart Lesions  Heart Problems  Pacemaker  Tobacco Habit  
 Artificial Joints, Pins, etc.  Cortisone Treatments  Hemophilia  Radiation Treatment  Tonsillitis  
 Asthma  Cough, Persistent  Hepatitis  Respiratory Disease  Tuberculosis  
 Back Problems  Cough up Blood  Hernia Repair  Rheumatic Fever  Ulcer  
 Bleeding Abnormally  Diabetes  High Blood Pressure  Scarlet Fever  Venereal Disease  
 Blood Disease  Epilepsy  HIV/AIDS  Shortness of Breath  Skin Rash  
 Cancer  Fainting  Jaw Pain  Stroke  
 Chemical Dependency  Glaucoma  Kidney Disease

**MEDICAL HISTORY CONTINUED**

Please list medications you are currently taking and the correlating diagnosis:

Allergies:

**AUTHORIZATION AND RELEASE**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I, or my minor child, ever have a change in health.

I certify that, I and/or my dependent(s), have insurance coverage with \_\_\_\_\_ (Insurance Company) and assign directly to \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-name dentist may use my health care information and my disclose such information to the above-name insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services This consent will end when the current treatment plan is completed or one year form the date signed below.

Signature of Patient, Guardian or Personal Representative:

---

Please Print Name of Patient, Guardian, or Personal Representative:

---

If Signature not of the Patient, Relation to Patient:

---

Date:

---

**PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED**