WELCOME to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Patient Information

Date ______________________

Name ____ Soc. Sec. # ____________________

Address ______________________________________ Driver's License # ________________

City ______________________________ State ____________ Zip Code ______________

Home Phone ____________________ Work Phone ______________ Cell Phone ______________

E-mail ____

Would you like us to send you appointment reminders by e-mail and/or text messaging? ____________

E-mail ______ Yes ______ No Text ______ Yes ______ No

Employer ____ Occupation ____________________

Birthdate ______________ Age ____ Sex ___M ___F Single ___ Married ___ Divorced ___ Widowed ___

Who May we thank for referring you? ____

In case of emergency, who should be notified? ______________________ Phone ______________

Responsible Party

Name ____ Soc. Sec. # ____________________

Address ______________________________ City ______________ State ______ Zip __________

Home Phone ____________________ Work Phone ______________ Cell Phone ______________

Employer ____ Occupation ____________________

Birthdate ____________________ Drivers Lic: ____________________

WE ARE NOT A MEDICAID PROVIDER. THEREFORE WE CAN NOT FILE WITH MEDICAID.

Primary Dental Insurance

Name of Insured ____________________ Date of Birth ________ Relationship to Insured ____________

Insured SS# ____________________ Insured Employer ________________________________

Insurance Company ____

Group # ______________________________ Phone Number ____________________________

Address ____

Additional Dental Insurance

Name of Insured ____________________ Date of Birth ________ Relationship to Insured ____________

Insured SS# ____________________ Insured Employer ________________________________

Insurance Company ____

Group # ______________________________ Phone Number ____________________________

Address ____

***** If you have your insurance card with you, please allow us to make a copy of it. *****

~~ PLEASE COMPLETE BOTH SIDES ~~

Dental History

Date of Last Dental Visit ___________ Date of Last Cleaning ___________ Were x-rays taken? ______

Have you had any serious trouble associated with past dental treatment? _______ If yes, please explain

____

Have you had any of the following:

____ Bleeding gums ____ Loose teeth ____ Sensitivity when biting

____ Periodontal treatment ____ Clicking or popping jaw ____ Sensitivity to hot/cold

Medical History

Physician's Name ______________________________ Date of last visit ____________

Have you had any serious illnesses or operations? If yes, please explain ____________________

____

(Women) Are you pregnant? ____ yes ____ no

Check if you have or have had any of the following:

___ AIDS	___ Cortisone treatments	___ Hepatitis	___ Rheumatic Fever
___ Anemia	___ High Blood Pressure	___ Scarlet Fever	___ Respiratory Disease
___ Arthritis	___ Diabetes	___ HIV Positive	___ Shortness of Breath
___ Artificial Heart Valves		___ Jaw Pain	___ Stroke
___ Artificial Joints	___ Epilepsy	___ Kidney Problems	___ Thyroid Problems
___ Asthma	___ Fainting	___ Liver Disease	___ Tobacco Habit
___ Back Problems	___ Glaucoma	___ Mitral Valve Prolapse	___ MS
___ Blood Disease	___ Headaches	___ Nervous Problems	___ Tuberculosis
___ Cancer	___ Heart Murmur	___ Pacemaker	___ Ulcer
___ Chemotherapy	___ Heart Problems	___ Radiation Treatment	___ Venereal Disease
___ Circulatory Problems		___ Hemophilia	___ Osteoporosis

MEDICATIONS

List medications you are currently taking:

____

____

____

ALLERGIES

Be sure to include any drug allergies !

____

____

____

Are you pre-medicated for Dental Procedures? Explain ______________________________

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions and the release of all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that all charges are due on the date of service. A penalty of 1 1/2 percent per month computed on the unpaid balance will be charged to any portion of my account that is overdue by 90 days. I will also be responsible for any collection or attorney's fees charged by parties who are not employees of the dentist in the collection of the account after it becomes past due.

Signature ______________________________ Date ______________
Patient/Person Responsible for Payment