WELCOME

ABOUT YOU

Today's Date____________________________________

Patient Name____________________________________

DOB___/____/_____ Age________ M_____F________

Social Security #_________________________________

Address____

____
(CITY) (STATE) (ZIP)

Home Phone_____________________________________

Cell Phone______________________________________

Email Address___________________________________

Employer_____________ Occupation_______________

Status- O Minor O Single O Married

Account Info

Who is responsible for account?______________________

Relationship_____________________________________

Billing Address___________________________________

____
(City) (State) (ZIP)

Drivers License #_________________________________

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

____
(Signature)

Insurance Info

Primary Dental Insurance Company____________________

Address____

Insurance ID #__________________Phone #_____________

Primary Insured Name___________________DOB__/__/___

Relationship____________________Group #____________

Insured Employer______________________________________

Secondary Dental Insurance Co________________________

Address____

Insurance ID #__________________Phone #______________

Insured Name_________________________DOB__/__/____

Relationship______________Group #___________________

Insured Employer______________________________________

Emergency Contact Info

Name____

Relationship____

Home Phone #____

Cell Phone #____

Work Phone #____

Who is your medical doctor?__________________________

Medical Dr. Phone #___________________________________

Do you have any of the following medical conditions?

- ○ **Aids/HIV**
- ○ **Anemia**
- ○ **Arthritis, Rheumatism**
- ○ **Artificial Heart Valves**
- ○ **Artificial Joints**
- ○ **Asthma**
- ○ **Back Problems**
- ○ **Bleeding abnormally with extractions /surgery**
- ○ **Blood disease**
- ○ **Cancer**
- ○ **Chemical Dependency**
- ○ **Chemotherapy**
- ○ **Circulatory Problems**
- ○ **Congenital Heart Lesions**
- ○ **Cortisone Treatments**
- ○ **Cough, persistent/bloody**
- ○ **Diabetes**
- ○ **Emphysema**
- ○ **Epilepsy**
- ○ **Fainting or dizziness**
- ○ **Glaucoma**
- ○ **Headaches**
- ○ **Heart Problems/Murmur**
- ○ **Hepatitis Type_____**
- ○ **Herpes**
- ○ **High Blood Pressure**
- ○ **Jaundice**
- ○ **Jaw Pain**
- ○ **Kidney Disease**
- ○ **Liver Disease**
- ○ **Low Blood Pressure**
- ○ **Mitral Valve Prolapsed**
- ○ **Nervous Problems**
- ○ **Pacemaker**
- ○ **Psychiatric Care**
- ○ **Radiation Treatment**
- ○ **Respiratory Disease**
- ○ **Rheumatic Fever**
- ○ **Venereal Disease**
- ○ **Scarlet Fever**
- ○ **Shortness of Breath**
- ○ **Sinus Trouble**
- ○ **Skin Rash**
- ○ **Stroke**
- ○ **Swollen Neck Glands**
- ○ **Thyroid Problems**
- ○ **Tuberculosis**
- ○ **Tumors, Head/Neck**
- ○ **Ulcer**

Are You Pregnant or Nursing?

____Yes_____No

Please list any medication you are currently taking:

____
____
____
____
____
____
____

Do You Have Any Allergies To The Following?

O PENICILLIN O ASPRIN O DENTAL ANESTHETICS

O LATEX O SULFUR O TETRACYCLINE

O OTHER, PLEASE LIST

____
____

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between providers and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 60 days of the date of service and no financial agreements have been made, you will be responsible for legal fees, collection fees, interest charges, and any other expenses occurred in collecting your account.
- I authorize staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE____DATE____