We are complemented that you have selected us to provide dental care for you and your family.

Patient Information

Date

Patient's Name — Last | First | Middle | Birthday

Address — Street | City | State | Zip

Drivers License Number: | Cell Number:

Home Phone: | Wk Phone: | Email:

Social Security #:

If patient is a minor, give parent's or guardian's name:

Responsible Party is other than patient:

Person to contact in case of emergency:

Complete Address:

Phone:

Insurance and Responsible Party Information

Primary Insurance (Self/Parent/Responsible Party)

Last | First | Middle

Street | City | State | Zip

Home | Work | Cell | Email

Birthday | Relationship to Patient

Employer | Dental ins. Co.

SS# | Subscriber # | Group #

Secondary Insurance (Spouse/Parent)

Last | First | Middle

Street | City | State | Zip

Home | Work | Cell | Email

Birthday | Relationship to Patient

Employer | Dental ins. Co.

SS# | Subscriber # | Group #

Method of Payment

☐ Responsible party payment information is already on file

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(Circle or Check One) ◯ Cash ◯ Check ◯ Visa ◯ MC ◯ Discover ◯ Other

Card # | Exp. Date

Name as it appears on card:

Auth Signature:

Security Code:

☐ I would like my insurance billed and any balance applied to my credit card (Please fill out the credit card information above

☐ I wish to discuss the Dental Office's Financial Policy

Patient Information

1. Please list all medications you are taking.

2. Please list all medications or anesthetics you are allergic or sensitive to.

Patient Information Cont'd

3. Please list all allergies.

4. Indicate which of the following you have had or have st present Circle or Check "Yes " or "No" to each item.

Heart Failure.....	YES	NO	Artificial Joints (Hip, Knee, Etc	YES	NO	Hepatitis B (serum).....	YES	NO
Heart Disease or Attack....	YES	NO	Kidney Trouble.....	YES	NO	Venereal Disease.....	YES	NO
Agina Pectoris.....	YES	NO	Ulcers.....	YES	NO	A.I.D.S.	YES	NO
Congential Heart Disease.	YES	NO	Diabetes.....	YES	NO	H.I.V. Positive.....	YES	NO
Heart Murmur.....	YES	NO	Thyroid Problems.....	YES	NO	Cold Sores/Fever Blisters..	YES	NO
High Blood Pressure.....	YES	NO	Glaucoma.....	YES	NO	Blood Transfusion.....	YES	NO
Arteriosclerosis.....	YES	NO	Cancer.....	YES	NO	Hemophilia.....	YES	NO
Mitral Valve Prolapse.....	YES	NO	Type			Anemia.....	YES	NO
Artificial Heart Valve.....	YES	NO	Emphysema.....	YES	NO	Sickle Cell Disease.....	YES	NO
Heart Pacemaker.....	YES	NO	Chronic Cough.....	YES	NO	Bruise Easily.....	YES	NO
Heart Surgery.....	YES	NO	Tuberculosis.....	YES	NO	Liver Disease.....	YES	NO
Rheumatic Fever.....	YES	NO	Asthma.....	YES	NO	Yellow Jaundice.....	YES	NO
Arthritis.....	YES	NO	Hay Fever.....	YES	NO	Epilepsy or Seizures.....	YES	NO
Rheumatism.....	YES	NO	Allergies or Hives.....	YES	NO	Fainting or Dizzy Spells.....	YES	NO
Cortisone Medicine.....	YES	NO	Sinus Trouble.....	YES	NO	Nervousness.....	YES	NO
Drug Addiction.....	YES	NO	Radiation Therapy.....	YES	NO	Tumors.....	YES	NO
Stroke.....	YES	NO	Chemotherapy.....	YES	NO	Developmentally Disabled....	YES	NO
Headaches.....	YES	NO	Hepatitis A (infectious).....	YES	NO	A.D.H.D.	YES	NO

5. Do you smoke?..... YES NO
6. Do you have or have you had any disease, condition, or problem not listed?..... YES NO

If yes, please list:

7. What is the name of the last dentist seen and when your last x-rays taken?

FOR WOMEN ONLY

Are you pregnant? YES Yes, what month?: NO

Are you nursing? ..... YES NO
Are you taking birth control pills?..... YES NO

AUTHORIZATION:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. I hereby authorize the doctor to take x-rays, study models, and photographs, or any other diagnosis aids deemed appropriate by the doctor to make a thorough diagnosis or the patient's dental needs.
3. I hereby authorize the doctor to take x-rays, study models, and photographs, or any other diagnosis aids deemed appropriate by the doctor to make a thorough diagnosis or the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me, and use the appropriate medication and therapy indicated for such treatment in connection with (name or patient) . I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor can choose and and employ such assistance as deemed fit to provide the recommended treatment.
4. I understand the it is my responsibility to advise your office of any changes tin the information contained in this form.
5. I understand that I am responsible for all costs of dental treatment at the time of services are rendered unless prior financial arrangements have been made. I authorize payment of insurance benefits to be made directly to the dental office. In the event payments are not received be the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account.
6. **I HAVE BEEN GIVEN A COPY OF THE OFFICE'S HIPPA PRIVACY POLICIES.**
7. I understand that collection fees may be charged to patients with balances that have been sent to collections.
8. I understand that cancellation fees may be charges for appointments that are not canceled 24 hours in advance.
9. I understand that this office is an out of network provider and all costs not paid by my insurance is my responsibility.
10. By signing my name, I acknowledge that I have read and understand the authorization terms.

Patient Date Field Witness

Parent or Responsible Party Relationship to Patient

FOR OFFICE USE:

Reviewed by Dr. Date