

WELCOME

We would like to take this opportunity to welcome and thank you for joining our dental practice. We appreciate your confidence in us and we will do everything possible to provide you with the finest dental care. Please take a few minutes to answer the following questions so we can assist you with your dental needs. The better we communicate, the better we can care for you.

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL.

ABOUT YOU

Today's date: _____
Month, Day Year

Social Security #: _____

Name: _____
Last, First, Middle Initial

I like to be called: _____

Home Address: _____

Apt/Condo# City State Zip Code

Email: _____

Home Phone: _____

Work Phone: _____ Ext.# _____

Beeper/Cell phone: _____

Mailing Address, If Different:

Address: _____

Apt/Condo# City State Zip Code

Your Employer: _____

Occupation: _____ How long held: _____

Birthday: _____ Male Female
Month Day Year

Single Married Divorced Widowed

Spouse's Name: _____

Referred by: _____

In the event of an emergency, is there someone who lives near you that we could contact?

Name: _____

Relationship: _____

Work #: _____

Home #: _____

INSURANCE BENEFITS

Primary Insurance Coverage

Medical Dental

Policy Holder: _____

SSN#: _____ Birthdate: _____

Insurance Company: _____

Carrier Address: _____
City State Zip Code

Group #: _____

Employer's Name: _____ Phone: _____

Employer's Address: _____

Do you have any other Insurance Coverage?

Yes No

This coverage is through Spouse Parent

Policy holder: _____

SSN#: _____ Birthdate: _____

Insurance Company _____

Carrier Address: _____
City State Zip Code

Group#: _____

Employer's Name: _____ Phone: _____

Employer's Address: _____

RELEASE OF INFORMATION

I authorize the release of any information necessary to process my claims.

Signature: _____

ASSIGNMENT OF BENEFITS

To avoid misunderstanding regarding insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare necessary forms or reports to help you to obtain your benefits from insurance companies. We do not render our services or the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient. There will be an additional fee for letter or reports.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be payable directly to the undersigned dentist and I am financially responsible for non-covered services. I also authorize the doctor to release any information requested.

I authorize treatment of the above-named person and agree to pay all fees charged for such treatment. I agree to pay all charges for members of my family and myself, shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing.

SIGNED: _____ DATE: _____
(Responsible Party) _____

MEDICAL HISTORY

DATE _____

Personal Physician's Name: _____

Address: _____

Phone: _____

The approximate date of your last doctors visit: _____

Your current physical health is: Good Fair PoorAre you currently under the care of any physician? Yes No

If yes, please explain: _____

Do you smoke or use tobacco in any other form? Yes NoAre you presently taking any drugs prescribed by a physician or dentist? Yes No

If yes, please list: _____

Are you taking aspirin? Yes NoAre you taking blood thinners? Yes NoAre you pregnant? Yes NoAre you taking birth control pills? Yes NoDo you need to be premedicated before dental treatment? Yes NoHave you had any serious medical problems in the last 5 years? Yes No

If yes, please explain: _____

Have you ever had any of the following diseases or medical problems?

Heart Attack/Stroke-	Y N	HIV+/AIDS	Y N
Mitral Valve Prolapse-	Y N	Shingles	Y N
Heart Murmur/Rheumatic Fever-	Y N	Kidney problems	Y N
Hip & Joint Replacement-	Y N	Sinus problems	Y N
Heart Surgery/Pacemaker-	Y N	Fever Blisters/Herpes	Y N
Chronic Hepatitis-	Y N	Psychiatric problems	Y N
Anemia	Y N	Diabetes	Y N
High/Low Blood Pressure-	Y N	Tuberculosis (TB)	Y N
Severe Headaches	Y N	Sickle Cell Disease	Y N
Epilepsy/Seizures/Fainting Spells-	Y N	Asthma	Y N
Drug/Alcohol Abuse-	Y N	Cardiac problems	Y N
Thyroid-	Y N	Lung problems	Y N
Hemophilia/Abnormal Bleeding-	Y N	Neurological problems	Y N
Cancer/Chemotherapy	Y N	Artificial joints or valves	Y N

Doctor's Comments: _____

Any other serious medical conditions:Have you experienced any that are not listed above? Yes No

If yes, please list: _____

Are you allergic to any of the following?

Penicillin	Y N	Tetracycline	Y N
Erythromycin	Y N	Codeine	Y N
Dental Anesthetics	Y N	Metals	Y N
Latex	Y N	Acrylics	Y N
Aspirin	Y N		

Are you allergic to any other drugs? Yes No

If yes, please list: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? Yes NoAre you under any unusual stress at home or work? Yes NoDo you experience stress or anxiety when you visit a dental office? Yes No

The approximate date of your last dental visit: _____

Have you ever experienced TMJ problems? Yes NoDo you grind your teeth? Yes No
(TMJ is pain or discomfort in your jaw joints.)Your current dental health is: Good Fair PoorDo you like to smile? Yes NoDo your gums ever bleed? Yes NoWould you like to prevent dentures? Yes NoWould you be interested in dental implants? Yes No

General Dentist:

Name: _____

Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Additional Notes: _____

APPOINTMENTS

So that we may assure you and other patients of uninterrupted treatment it is necessary for all patients to accept a definite arrangement for the appointments, Once an appointment is made, please remember this time is reserved for you.

AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY. OTHERWISE A CANCELLATION CHARGE OF \$75.00 WILL BE MADE.

PATIENT'S SIGNATURE _____

DATE _____