



Cover Page

Please print this document, complete the forms on the following two pages and bring them with you to your appointment.

Patient Information

Welcome!

Patient Name.....**Name you prefer to be called**.....
Birthdate..... Social Security Number.....
Address..... City, Zip.....
Home Phone..... Cell Phone.....
Work Phone..... May we call at work? Y N
Employer or School.....

Person Financially Responsible..... Birthdate.....
Relationship to patient..... Social Security Number.....
Address..... City, Zip.....
Home Phone..... Cell Phone.....
Work Phone..... May we call at work? Y N

Family Members

Spouse/Parent.....
Other.....

Who referred you to our office?.....
(We would like to thank them with a \$20 referral credit)

Primary Dental Insurance

Employee (if different from patient)..... Birthdate.....
Address (if different from patient).....
Social Security Number (if different from patient).....
Employer..... Insurance Company.....
Insurance Company Address.....
Insurance Company Phone..... Group #.....

Secondary Dental Insurance

Employee (if different from patient)..... Birthdate.....
Address (if different from patient).....
Social Security (if different from patient).....
Employer..... Insurance Company.....
Insurance Company Address.....
Insurance Company Phone..... Group #.....

I hereby authorize payment of the **dental benefits** otherwise payable to me directly to the dentist or practice. This authorization is binding for a period of two years from the date signed.

Signature(patient or guardian)..... **Date**.....

I have been informed of the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my **dental benefit plan**, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relation to this claim. This authorization is binding for a period of two years from the date signed.

Signature(patient or guardian)..... **Date**.....

MEDICAL HISTORY

When was your last comprehensive dental examination?.....Dentist name and #.....

Have you had any serious illnesses in the past 5 years? Yes No

Please list.....

Are you taking any medications or pills? (Include Birth Control pills) Yes No

Please list

Are you taking any nutritional supplements or alternative medications? Yes No

Please list

Do you now or have you ever used tobacco products? (i.e.: chew, smoking) Yes No If yes, when?.....

Do you have a history of alcohol or chemical dependency? Yes No

If yes, how long have you been in recovery?.....Anniversary date.....

Have you ever taken or been advised to take an antibiotic before dental treatment? Yes No

Have you ever had a blood test for hepatitis or HIV? Yes No

Results were: Neg Pos

(Women) Are you pregnant or trying to become pregnant? Yes No

Please circle if you have an allergy to any of the following:

Latex	Penicillin	Sulfa
Aspirin	Codeine	Sedatives
Local Anesthetics		
Others.....		
Foods (list).....		

Circle any of the following which you presently have or previously had:

AIDS	Diabetes	Rheumatic Fever
Anemia	Heart Murmur	Seizure Disorder (Epilepsy etc)
Angina	Heart Issues	Stroke
Arthritis	Hepatitis A,B,C,D	STDs
Artificial Heart Valves	Herpes	Tuberculosis
Artificial Joints	High or Low Blood Pressure	COPD
Asthma	Kidney Issues	
Cancer	Mitral Valve Prolapse	
	Mitral Valve Prolapse with regurgitation	

Who is your physician?.....

Is there anything else we should know about you?.....

I agree to be responsible for all charges for dental services. (Important: We are always willing to discuss fees and financial arrangements at any time. Payment is due in full at time of service unless other arrangements have been made.)

Date.....Signature.....