Welcome

We are pleased to welcome you 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. We look forward to working with you in maintaining your dental health.

Patient information

Date _____ Home Phone ( ) _____ Cell Phone ( ) _____

Name _____ SS # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex □ M □ F Age ____ Birthdate _____ □ Married □ Widowed □ Single □ Minor

□ Separated □ Divorced □ Partenered for ____ years

Patient Employer/School _____ Occupation _____

Employer/ School Address _____ Employer/ School Phone ( ) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone ( ) _____

Primary insurance

Person responsible for the account _____

Relation to patient _____ Birthdate _____ SS # _____

Address (if different from patient's) _____ Phone ( ) _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Business address _____ Business phone ( ) _____

Insurance company _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional insurance

Is patient covered by additional insurance? □ Yes □ No

Subscriber name _____

Relation to patient _____ Birthdate _____ SS # _____

Address (if different from patient's) _____ Phone ( ) _____

City _____ State _____ Zip _____

Subscriber employed by _____ Business phone ( ) _____

Insurance company _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please complete both sides

Dental history

Reason for today's visit _____ Date of last dental care _____

Former dentist _____ Date of last dental X-Rays _____

Address & Tel. _____

Check (√) if you have had problems with any of the following:

□ Bad breath	□ Grinding teeth	□ Sensitivity to hot
□ Bleeding gums	□ Loose teeth or broken fillings	□ Sensitivity to sweets
□ Clicking or popping jaw	□ Periodontal treatment	□ Sensitivity when biting
□ Food collection between teeth	□ Sensitivity to cold	□ Sores or growths in your mouth

How often do you brush? _____ How often do you floss? _____

Medical history

Physician's name _____ Date of last visit _____

Have you ever taken any group of drugs collectivelly referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Have you had any serious illnesses or operations? □ Yes □ No If yes, please describe _____

Have you ever had blood transfusion? □ Yes □ No If yes, give approximate dates _____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (√) if you have or have had any of the following:

□ Anemia	□ Cortisone treatments	□ Hepatitis	□ Scarlet fever
□ Arthritis, Rheumatism	□ Cough, persistent	□ High blood pressure	□ Shortness of breath
□ Artificial heart valves	□ Cough up blood	□ HIV/AIDS	□ Skin rush
□ Artificial joints	□ Diabetes	□ Jaw pain	□ Stroke
□ Asthma	□ Epilepsy	□ Kidney disease	□ Swelling of feet or ankles
□ Back problems	□ Fainting	□ Liver disease	□ Thyroid problems
□ Blood disease	□ Glaucoma	□ Mitral valve prolapse	□ Tobacco habit
□ Cancer	□ Headaches	□ Pacemaker	□ Tonsillitis
□ Chemical dependency	□ Heart murmur	□ Radiation treatment	□ Tuberculosis
□ Chemotherapy	□ Heart problems	□ Respiratory disease	□ Ulcer
□ Circulatory problems	□ Hemophilia	□ Rheumatic fever	□ Venereal disease

MEDICATIONS

List medications that you are currently taking

_____

ALLERGIES

_____

Consent for services

APPOINTMENTS: Once an appointment is made, please remember this time has been reserved especially for you. If you cannot keep the appointment, kindly give at least 24 hours notice, so that we can reallocate that time; otherwise a minimum charge will be applied to your account.

PAYMENTS: As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

_____ Date _____ Relationship to patient _____

Signature of patient, parent or guardian