PATIENT INFORMATION AND HEALTH HISTORY

We are honored that you have selected us to provide for your dental care. Please complete this new patient information and medical and dental history form. (This information is necessary for our files and will be considered confidential.)

Personal Information

Purpose of Visit: _____ Today's Date: _____

Patient's Name _____ Birthday: _____
Last First Middle Initial

Residence Address: _____ Home Phone ( ) _____
Street City Zip

E-mail Address: _____ Cell Phone ( ) _____

Is: ☐ Married ☐ Single ☐Minor ☐Other Driver's License No. _____ Social Security No. _____

Employed by: _____ How Long? _____ Occupation: _____

Business Address: _____ Work phone (_____) _____
Street City Zip

Spouse's Name: _____ Social Security No. _____

Employed by: _____ How Long? _____ Occupation: _____

Business Address: _____ Day Phone: (_____)_____
Street City Zip

Name of nearest relative not living with you: _____ Relationship: _____

Complete Address: _____ Evening Phone: (_____)_____

Name of Physician: _____
Name Address City Telephone

Name of General Dentist: _____
Name Address City Telephone

Who may we thank for referring you? _____

Financial Information

Person responsible for this account: _____ Relationship: _____

Address if different from above: _____

If you have insurance that may assist you with some of your dental care please list your insurance carriers.

Dental Insurance

Name of Insurance Company: _____

_____

Insured Person's Name Birthdate Relationship Social Security No.

_____

Name of Group Dental Plan Group No. Plan No. Name of Union Local

Secondary Dental Insurance Company: _____

_____

Insured Person's Name Birthdate Relationship Social Security No.

_____

Name of Group Dental Plan Group No. Plan No. Name of Union Local

Dental Records

The dental records policy of this office reflects the patient's right to expect that his/her dental records be treated in confidence. Dental records that are the property of the office and are maintained for the benefit of the patient and doctor.

Dental Records Release: I hereby consent to the release of dental records, x-rays and photographs obtained in the diagnosis and treatment of my dental needs to be used for documentation, education, insurance filing and the advancement of dentistry and to be used by other doctors involved in my care.

Signature: _____ Date: _____

Consent for Treatment

I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this form to administer such anesthetics and analgesics to obtain the necessary records and photographs and to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. The patient (parent or guardian) is fully responsible for total payment of all services performed in this office including any amounts not covered by any health insurance program the responsible party may have. A finance charge of 18% per annum is charged to balances after 90 days. Should collection procedures be required to collect a past due account, I will pay all fees associated with said collection procedures as allowed by law.

Signed: _____ Date: _____ Relationship to patient: _____