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PLEASE COMPLETE BOTH SIDES OF FORM

Patient Information

Patient Name: ____ Date: ____________
Last, First MI (Preferred Name)

Male Female Married Single Child Other

Social Security #: ____________________ Birth Date: ____________ E-Mail Address ____________________________

Phone (Home): __________________________ (Work): _______________ (Other/Cell): _______________________

Address: ____ ____
Street Apartment #

____ ____
City State Zip Code

Patient's Employer/School: ____

Occupation: ____

Spouse/Parent's Name: _____________________________________ Spouse/Parent's Birth Date: _________

Spouse/Parent's Social Security # ___________________ Spouse/Parent's Employer: ________________________

Who is responsible for this account? ____

Relationship to Patient: ____

Does patient have dental insurance? Yes No

Name and birth date of insured/subscriber ____

Name and address of dental insurance company ____

_______________________________ Insured's ID # _______________________ Group # _________________________

Is patient covered by secondary dental insurance? Yes No

Name and birth date of insured/subscriber ____

Name and address of secondary insurance ____

________________________________ Insured's ID # ______________________ Group # _________________________

Referral Information

Whom may we thank for referring you to our practice? ____

Health Information

Date of Last Dental Visit: ___________________ Reason for this visit: ___________________________________

Name of previous dentist/dentists: ____

Have you ever had any of the following? Please check those that apply:

AIDS/HIV
Allergies ___________
Arthritis
Anemia
Artificial Heart Valve
____
Artificial Joint Replacements________
____
Asthma
Blood Disease
Cancer
Chemical Dependency
Diabetes
Epilepsy
Excessive Bleeding
Glaucoma

Liver Disease
Head Injuries
Heartburn-GERD
Heart Disease
Heart Murmur
Hepatitis
High Blood Pressure
Kidney Disease
Medications for bones
Mental Disorders
Nervous Disorders
Osteoporosis
Organ Transplants
____
Pacemaker
Pregnant Now?
Due Date:__________

Rheumatism
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Sexually Transmitted Disease
Sinus Problems
Stomach Problems
Stroke
Thyroid Problems
Surgeries-Past/Future
____
Smoking Habit
How often?__________
Tobacco Habit
How often?__________
Tuberculosis

Tumors
Ulcers
____
Codeine Allergy
Penicillin Allergy
Latex Allergy
OTHER ALLERGIES
____

____

Are you currently taking:
Blood Thinners
Heart Medications
Bisphosphonates

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: ____

- List any medications, herbal supplements, or vitamins you are now taking: ______________________________

____

____

- Are you now seeing a physician, or being treated for any medical problems? ☐ Yes ☐ No

  If yes, please explain: ____

- Name of Physician: ____ Phone: ___________________

- Do you have or had any other medical problems or surgeries, such as joint replacements, heart surgery? Yes No

  If yes, please explain: ____

Consent for Services

In fairness to all patients, this office charges for missed appointments without 24 hrs. prior notice.
You are responsible to know your own dental insurance and benefits.
X-rays and fluoride treatments will be done at the doctors discretion.
I agree to be responsible for all charges. Patients who have dental insurance authorize payments to be made directly to the doctor, and the release of any information relating to claims. We will be glad to submit claims for you, however you are ultimately responsible for the charges.
I grant my permission for the office staff to contact me by phone calls, message on answering machine, or postcards regarding appointments.
HIPPA CONSENT: I have seen and been given the opportunity to review this office's Notice of Privacy Practices. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I have read the above conditions of treatment and payment and agree to their content.

____**Date:**_______________ **Relationship to patient**______________________
Signature of patient, parent or guardian