PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name____
Last First MI (Preferred)

Birthdate__________SS#_____________________DL#_____________Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Address____

City___________________________State________Zip______________

Home Phone_________________Cell Phone____________________Email______________________________

Current Employer: Address ____

City___________________________State________Zip______________

How did you hear about us? (Please be specific so we can thank them!)____________________________________

Preferred Appointment Confirmation Type: [ ] Text Message [ ] Phone Call [ ] Postcard

If patient is under 18 yrs, please also complete the following:

Guarantor *Name*____
Last First MI (Preferred)

Birthdate__________SS#_____________________DL#_____________Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Address (if different than above)________________________________

City_____________________State______________Zip_____________

Home Phone_________________Cell Phone____________________Email______________________________

INSURANCE POLICY 1

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ]Child

Subscriber Name________________________________Sub.ID #_____________________Sub.DOB__________

Insurance Company____Phone_____________________________

Employer___________________________Group Name______________________Group #_________________

INSURANCE POLICY 2

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ]Child

Subscriber Name________________________________Sub.ID #_____________________Sub.DOB__________

Insurance Company____Phone_____________________________

Employer___________________________Group Name______________________Group #_________________

Comments:____

Please complete reverse side.

MEDICAL HISTORY

Name of Medical Doctor:____City/State___________________________

Emergency Contact__________________________Phone__________________Relationship____________________

List all the medications or drugs you are now taking:

[ ] None

____

____

____

Check medications or drugs you are allergic to:

[ ] None
[ ] Aspirin
[ ] Codeine/ Other Narcotics
[ ] Erythromycin
[ ] Latex Rubber
[ ] Local Anesthetics
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Other: ___________

Check any medical conditions you may have:

[ ] None
[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Anemia/Leukemia
[ ] Anorexia/Bulimia
[ ] Arthritis
[ ] Asthma/Hay Fever
[ ] Blood Clotting Problems
[ ] Blood Transfusion
[ ] Bronchitis
[ ] Cancer/Tumor or Growth
[ ] Cardiac Pacemaker
[ ] Chest Pain Upon Exertion
[ ] Damage Heart Valve
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting Spells/Seizures
[ ] Fever Blisters/Herpes
[ ] Frequent Headaches
[ ] Frequently Dry Mouth/Sjogren
[ ] Gall Bladder Trouble
[ ] Heart Attack/Stroke
[ ] Heart Disease/Angina
[ ] Heart Murmur
[ ] Hepatitis/Jaundice
[ ] High Blood Pressure
[ ] Hives/Skin Rash
[ ] Joint Replacement, Date of: __________
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Problems
[ ] Mitral Valve Prolapse
[ ] Persistent Diarrhea
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Sexually Transmitted Disease
[ ] Sinus Trouble
[ ] Stomach Ulcers
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Other: ____

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? [ ] Yes / [ ] No
Do you want whiter teeth? [ ] Yes / [ ] No Do you want a straighter smile? [ ] Yes / [ ] No
Do you snore at night? [ ] Yes / [ ] No
Tobacco use? If so, what kind and how much?____
Unusual reaction to dental injections?____

Patient Agreement

*By signing this statement, I understand that billing of my insurance is a courtesy to me. The patient portion of a particular dental service(s) is ESTIMATED and due at the time of service or according to your payment plan agreement. I understand that I am financially responsible for payments in full for all applicable accounts, this includes any deductible amount, co-insurance or any other balance not paid for by my insurance company. If sent to collections, I agree to pay a 40% fee, all attorney fees, interest (1.8% monthly), and court costs accrued as a result of past due balances. Additionally, I understand that repeated cancellations and no-shows for appointments may result in additional fees or dismissal.

*By signing below, I certify that all of the above information is true to the best of my knowledge.

*I have received a copy of this office's Notice of Privacy Practices.

____ ____________________
Patient/Guardian Signature Date

____
Patient/Guardian Name (printed)