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 INFORMATION

Patient Name____
Last First MI (Preferred)

Date of Birth___________SS#_________________DL#________________Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Address____ City______________________________

State_____________Zip__________________

Home Phone__________________Mobile Phone__________________Email_____________________________

Current Employer: ____________________________ Employer Phone #: _________________________________

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

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

When was your last dental visit?____

Reason for today's office visit?____

Want whiter teeth? [ ] Yes [ ] No Want a straighter smile? [ ] Yes [ ] No Snore at night? [ ] Yes [ ] No

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

Guarantor Name____
Last First MI (Preferred)

Date of Birth ___________SS#_________________DL#______________Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Address (if different than above)________________________________City______________________________

State______________Zip_________

Home Phone_________________Cell Phone____________________Email______________________________

INSURANCE POLICY INFORMATION

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child *****PLEASE PRESENT YOUR DENTAL ID CARD*****

Subscriber Name_________________________________Sub.ID #_____________________Sub.DOB__________

Insurance Company____Phone____________________________

Employer____________________________Group Name_______________________Group #__________________

Is patient covered by another insurance? [ ] Y [ ] N Is patient a student? [ ] Y [ ] N [ ] Full-time [ ] Part-time

INSURANCE BILLING

Our office provides insurance billing as a courtesy to our patients. The patient portion of dental services is **estimated only** and not guaranteed. All patient portions are due at the time of service. This amount may be subject to adjustment when claims are adjusted by the insurance company. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance company. I understand that I am solely responsible for monitoring my insurance plans limitations, coverage and benefits and it is not the responsibility of my dental care provider. I acknowledge that I am responsible for any and all balances due.

Patient/Guardian Signature________________________________ Date______________

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	[ ]	Diabetes	[ ]	Joint Replacement, Date of: __________
[ ]	AIDS/HIV	[ ]	Emphysema	[ ]	Kidney/Bladder Trouble
[ ]	Alcohol/Drug Abuse	[ ]	Epilepsy	[ ]	Liver Disease
[ ]	Anemia/Leukemia	[ ]	Fainting Spells/Seizures	[ ]	Low Blood Pressure
[ ]	Anorexia/Bulimia	[ ]	Fever Blisters/Herpes	[ ]	Mental Health Problems
[ ]	Arthritis	[ ]	Frequent Headaches	[ ]	Mitral Valve Prolapse
[ ]	Asthma/Hay Fever	[ ]	Frequently Dry Mouth/Sjogren	[ ]	Persistent Diarrhea
[ ]	Blood Clotting Problems	[ ]	Gall Bladder Trouble	[ ]	Rheumatic Fever
[ ]	Blood Transfusion	[ ]	Heart Attack/Stroke	[ ]	Rheumatic Heart Disease
[ ]	Bronchitis	[ ]	Heart Disease/Angina	[ ]	Sexually Transmitted Disease
[ ]	Cancer/Tumor or Growth	[ ]	Heart Murmur	[ ]	Sinus Trouble
[ ]	Cardiac Pacemaker	[ ]	Hepatitis/Jaundice	[ ]	Stomach Ulcers
[ ]	Chest Pain Upon Exertion	[ ]	High Blood Pressure	[ ]	Thyroid Problems
[ ]	Damaged Heart Valve	[ ]	Hives/Skin Rash	[ ]	Tuberculosis

[ ] Other: ____

Tobacco use? If so, what kind and how much?____
Unusual reaction to dental injections or general anesthesia? [ ] Yes [ ] No Note: ________________________
Does your doctor recommend you take pre-med with antibiotics prior to any dental treatment? [ ] Yes [ ] No
WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? [ ] Yes [ ] No

Patient Agreement

*By signing this statement, I understand that any 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 this statement, I agree to being contacted by phone, text messages or e-mails, using the information I have provided. Methods of contact may include using pre-recorded or automated messages. I agree and understand that these methods of contact may be used in an attempt to collect any amounts owed, for scheduling and billing messages, or for other information deemed relevant to my patient care. I agree to update this office if my mobile number, and other contact information changes.

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

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

____________________________________ ____________________

Patient/Guardian Signature Date

____

Patient/Guardian Name (printed)