1 About You

Today's Date ___________/___________/___________
Patient's Name________________________________
Parent, if minor:________________________________
Sex:M F Status: Single Partner Married Divorced
Birthdate_________/_________/________Age_______
Address____
City, ZIP____
Home Phone (______)_________-________________
Work Phone (______)_________-________________
Cell Phone (______)_________-________________
Email: ____
Referred by: ____________________________________
Employer: ____________________________________
Work Address: ___________________________________
City, ZIP: ______________________________________
Occupation: _____________________________________

2 Insurance Information

Primary Dental Insurance
Insured's Name __________________________________
Insured's ID # ___________________________________
Relation to Patient: ______________________________
Birthdate: ___________/____________/___________
SS#: ____________/____________/______________
Employer: _______________________________________
Insurance Co. ____________________________________
Address: ____
____
Phone: (________)_____________-__________________
Group# ____

Secondary Dental Insurance
Insured's Name __________________________________
Insured's ID # ___________________________________
Relation to Patient: ______________________________
Birthdate: ___________/____________/___________
SS#: ____________/____________/______________
Employer: _______________________________________
Insurance Co. ____________________________________
Address: ____
____
Phone: (________)___________-___________________
Group# ____

3 Office Financial Policy

Cash Patients: Payment is due on the day of services rendered- by cash, check or credit card

Insurance Patients: We'll calculate the amount insurance will cover, and the amount that is your responsibility including any deductible. Then you can pay your portion on the day services are rendered by cash, check or credit card. Reduction or rejection of your claim by your insurance company means you're still responsible for the charges incurred in your account.

Our office reserves the right to charge for missed or broken appointment. We request that you give us 48-hour notice if it becomes necessary for you to reschedule your visit.

_________ I hereby authorize assignment
initials of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

4 Emergency Contacts

Whom shall we contact? ___________________________
Relation: ____
Home Phone (________)___________-__________________
Work Phone (________)___________-__________________
Cell Phone (_________)____________-________________
Who is your Medical Doctor? _______________________
Doctor's Phone (________)___________-______________

PLEASE CONTINUE ON BACK

5 Medical History

Please list all **medications** you are currently taking (including birth control pills, over the counter meds such as vitamins, herbal remedy, aspirin, etc.)

	Medicine	Dosage	Reason or Condition
1.	______________________	__________	_________________________
2.	______________________	__________	_________________________
3.	______________________	__________	_________________________
4.	______________________	__________	_________________________
5.	______________________	__________	_________________________

Do you usually take Premedication (Antibiotics) before dental appointments? **Y N** ___________

Medical conditions- currently or had in past: (circle)

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Allergies
Y N Anemia
Y N Angina Pectoris
Y N Arthritis
Y N Artificial Heart Valve
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Facial Surgery
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Headaches

Y N Glaucoma or Cataracts
Y N HIV+, AIDS
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis A
Y N Hepatitis B
Y N Hepatitis C
Y N High or Low Blood Pressure
Y N Joint Replacement
Y N Kidney Problems
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Osteoporosis
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Therapy
Y N Rheumatic Fever
Y N Seizures
Y N Sexually Transmitted Disease
Y N Shingles

Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcers

Anything Else Not Listed:
____
____
____

Allergies: (circle)

Aspirin	Penicillin
Codeine	Sulfa
Erythromycin	Tetracycline
Latex	Amoxicillin

If Female, Please Answer

Y N Are you taking Birth Control Pills
Y N Are you pregnant?
If so, # of weeks ________
Y N Are you nursing?

6 Personal Habits

Y N Tobacco (circle) Smoke Chewing Cigar How much __________ How long __________
Y N Alcohol- (circle) 1-2/day, 1-2/wk, 1-2/mo, rare
Y N Soda - (circle) Diet, Non-Diet, Energy Drinks, 1-2/day, 1-2/wk, 1-2/mo, rare

**I authorize the staff and dentist to perform any necessary services needed during diagnosis and treatment. I also authorize the office to release any information required to process insurance claims.

**I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE:____**DATE:**_______________