GENERAL PATIENT INFORMATION

Patient Information
Full Name: _____
Date of Birth: _____
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Sex: □ Male □ Female
Social Security Number: _____
Email Address: _____
Home Phone Number: _____
Cell Phone Number: _____

Drivers License
Number: _____

Home Address:
Address: _____
City, State and ZIP: _____

Billing Address:
Address: _____
City, State and ZIP: _____

Work Information
Employer: _____
Occupation: _____
Work Phone Number: _____

Method of Contact: □ Phone □ Email □ Either Phone or Email

Emergency Contact:
Full Name: _____
Phone Number: _____
Relation: _____

Who may we thank for referring you? _____

AUTHORIZATION

I grant authority to the Dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures & photographs that may be necessary, and to discuss dental treatment with other doctors as necessary.

I/we agree to pay a finance charge of 1.5% per month (an annual rate of 18%) on the unpaid balance after 60 days and collection costs and or/ reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit.

I/we hereby authorize release of any information relating to dental treatment and dental claims.

I/we agree to be responsible for payment of services not covered by insurance.

_____ _____
Patient Signature Date

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)
Guarantor Name: _____
Social Security: _____
Relation to Patient: _____
Patient's Student Status
Student Status: _____
College: _____
Primary Dental Insurance Company *(If you have your insurance card no need to fill out**)***
Subscriber Name: _____
Date of Birth: _____
Social Security: _____
Employer: _____
Policy Number: _____
Group Number: _____
Coverage Type: □ Individual □ Family □ Prepaid / Capitation
Insurance Company: _____
Company Phone Number: _____
Company City, State, ZIP: _____
Secondary Dental Insurance Company *(If you have your insurance card no need to fill out**)***
Subscriber Name: _____
Date of Birth: _____
Social Security: _____
Employer: _____
Policy Number: _____
Group Number: _____
Coverage Type: □ Individual □ Family □ Prepaid / Capitation
Insurance Company: _____
Company Phone Number: _____
Company City, State, ZIP: _____

PATIENT CONSENT (must sign if you have dental insurance**)**

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. We are allowed to release this information to your insurance company or as necessary to get paid for our services. You can have access to your records by simply asking.

By agreeing with this consent form, you permit the release of any information to or from your dental practitioner as may be required.

You certify that you, and/or your dependent(s), have insurance coverage as submitted on the following registration form and assign directly to your dental practitioner all insurance benefits, if any, otherwise payable to you for services rendered. You understand that you are financially responsible for all charges whether or not paid by insurance. You authorize the use of your signature on all insurance submissions. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Signature: _____ Date_____

PATIENT MEDICAL HISTORY

Physician Information

Physician's Full Name: _____
City, State and ZIP: _____
Are you currently under a physician's Care? □ Yes □ No
If Yes, for what?_____
Have you been hospitalized in the last two years? □ Yes □ No
If Yes, for what?_____
Are you taking any medication, drugs or pills? □ Yes □ No
If so, please list the names and dosages of each:_____

_____
Do you Smoke? □ Yes □ No
How Much? _____

Women Only

Are you pregnant? □ Yes □ No Are you taking birth control pills? □ Yes □ No
Are you nursing? □ Yes □ No Are you on Hormone Therapy? □ Yes □ No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts- Check here if none _____

□ Allergic to Penicillin	□ Pre-Medication required	□ Mitral Valve Prolaspe
□ Allergic to Codeine	□ Pacemaker	□ Heart Problems
□ Allergic to Tetracycline	□ Allergic to Sulpha	□ HIV Positive
□ Allergic to Aspirin	□ Allergic to Latex Rubber	□ Prior Hepatitis
□ Other		

Medical Conditions-

□ Heart Attack	□ Excessive Bleeding	□ Chemotherapy	□ Osteoporosis
□ Heart Murmur	□ Sickle Cell Disease	□ Ulcers	□ Swelling of Feet/Ankles
□ Chest Pain	□ Glaucoma	□ Gastrointestinal Upset	□ Artificial Joint Replacement
□ Congenital Heart Problem	□ Diabetes	□ Acid Reflux	□ Psychiatric Care
□ Artificial Heart Valve	□ Excessive Thirst	□ Lung Disease	□ Epilepsy or Seizures
□ Heart Surgery	□ Scarlet Fever	□ Tuberculosis	□ Extreme Nervousness
□ High/Low Blood Pressure	□ Thyroid Disease	□ Shortness of Breath	□ Fainting or Dizziness
□ Rheumatic Fever	□ Parathyroid Disease	□ Emphysema	□ Hypoglycemia
□ Anemia	□ Kidney Disease	□ Asthma	□ Hives
□ Blood Disease	□ Liver Disease	□ Sinus Trouble	□ Cold Sores/Fever Blisters
□ Blood Transfusion	□ Hepatitis A or B	□ Hay Fever	□ Venereal Disease
□ Stroke	□ Yellow Jaundice	□ Frequent Cough	□ Herpes
□ Deep Vein Clot	□ Cancer	□ Rheumatism	□ Cortisone Treatment
□ Hemophilia	□ X-Ray or Cobalt Treatment	□ Arthritis/Gout	□ Chemical Dependency

Check here if none of the above _____

If other please list: _____
_____

PATIENT DENTAL HISTORY

What is your primary reason for seeking dental care?_____

Previous Dentist Information

Dentist's Full Name:

_____

City, State and ZIP:

_____

Month and Year of Last Visit: _____

Date of Last full mouth x-rays: _____

How often do you visit the dentist? □ Annual Check Up □ Twice a Year Check Up

□ Only when I have a problem □ Other

Please choose the appropriate answer

Are you nervous about receiving dental treatment? □ Yes □ No

Do you gag easily? □ Yes □ No

Have you had excessive bleeding after an extraction? □ Yes □ No

Do you have any dental implants? □ Yes □ No

Do you wear dentures (partials or full)? □ Yes □ No

Do you smoke or chew tobacco? □ Yes □ No

Are your teeth sensitive to hot, cold, pressure or sweets? □ Yes □ No

Do you have a dry mouth? □ Yes □ No

Does food catch between your teeth? □ Yes □ No

Would you like whiter teeth? □ Yes □ No

Have you had periodontal (gum) treatments? □ Yes □ No

Do you regularly use dental floss? □ Yes □ No

Do you grind or clench your teeth? □ Yes □ No

Do you hear a "clicking" sound when you open/close your mouth? □ Yes □ No

Does your jaw ever get "stuck?" □ Yes □ No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____ Date_____