Please complete the following confidential information

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

Date _____

Name _____
First Middle I. Last

Spouse _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Sex F M

Birthdate _____ Age _____

Social Security _____

Date _____

Name _____
First Middle I. Last

Address _____

City _____ State _____ Zip _____

Home Phone _____ Sex F M

Birthdate _____ Age _____ Grade _____

Social Security _____

If your child's name and address are not the same as yours, fill in the box above also.

2

DENTAL INSURANCE

Primary Carrier

Insurance Co. _____

Address _____

_____

Effective Date _____

Employee _____

Group # _____

Subsciber # _____

Married _____ Single _____

Divorced _____ Widowed _____

Phone # _____

Secondary Carrier

Insurance Co. _____

Address _____

_____

Effective Date _____

Employee _____

Group # _____

Subsciber # _____

Phone # _____

You should look upon your insurance policy as a device which may reimburse you for dental procedures. As a courtesy to you, we will complete the forms necessary pertaining to your claim and submit them to your insurance carrier. As we are not a party to the agreement between you and your insurance carrier, we are not responsible for how much and when they pay your claim. You are responsible, at the time of service for payment of any deductible, co-payment, and any estimated balance not payable by your insurance company. The remainder of the bill is to be paid 45 days from the date services are provided.

3

GETTING TO KNOW YOU

If another member of your family, or a relative, is a patient at our office, please share their name _____

How did you learn about our office? _____

Closest relative or friend, not living with you, that we can contact in case of an emergency.

Name _____

Address _____

_____

Phone _____

4

ACCOUNT INFORMATION

Person responsible for account

_____
First Middle I. Last

Social Security # _____

YOUR:

Name _____

Occupation _____

Employer _____

Bus. Address _____ City _____

Bus. Telephone _____ Ext. _____

YOUR SPOUSE:

Name _____

Occupation _____

Employer _____

Bus. Address _____ City _____

Bus. Telephone _____ Ext. _____

MEDICAL HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the last two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   Physician Name _____ Phone _____
   Address _____
6. Are you taking any medications, drugs, natural herbs or supplements? ..... YES NO
   If yes, please list those drugs _____
7. Are you allergic or have you reacted severly to any of the following medications? (Please circle if yes)

Aspirin	Nitrous Oxide	Valium	Penicilin	Latex
Darvon	Erythomycin	Scopolamine	Other Antibiotics	
Codeine	Tetracycline	Local Anesthetic	(Novacaine or Xylocaine)	
Demerol	Percodan	Nembutal/Seconal	(Sleeping pills)	

8. Are you aware of being allergic to any other medication or substance? ..... YES NO
   If yes, please list _____
9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	Artificial Joints (Hip, Knee)
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congential Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Veneral Disease (Syphilis, Gonorrhea)
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotheraphy (Cancer, Leukemia)	Fever Blisters
Artificial Joint	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Anemia
AIDS	Oral Lesions	Bruise Easily

10. Do you have any reason to suspect you have been in contact with the AIDs virus? ..... YES NO
11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath or because you are very tired? ..... YES NO
12. Do your ankles swell during the day? ..... YES NO
13. Do you use more than 2 pillows to sleep? ..... YES NO
14. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
15. Do you ever wake up from sleep short of breath? ..... YES NO
16. Are you on a special diet? ..... YES NO
17. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
18. Do you have any disease, condition or problem not listed? ..... YES NO
19. Have you taken any prescription diet pills such as Pondimum, Redux, Phen-Fen, etc.? ..... YES NO

FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No If yes, what month? _____ Are you taking birth control pills? ☐ Yes ☐ No

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1½% billing charge (18% annually) will be added to any balance over 30 days. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I agree that a consumer credit may be obtained.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

*Minimum Billing Charge of $2.00 will be charged on all past due accounts.