To Our Patients:

Welcome to our office! Our first responsibility to you and your family is to provide the utmost in dental care. We would appreciate your furnishing us with the following information, which will be used in strict confidence to prepare your clinical records.

Today's Date:_______________________________________

Patient Information (Confidential)

Patient's Full Name:_______________________________________

Sex: **Male** **Female** **Birth Date:**_________________________ **SSN:**________________________

Patient's Street Address:_______________________________________

City:____ **State:**_____________ **Zip:**__________________

Home Ph #____________________ **Work Ph #**_____________________ **Cell Ph #**____________________

Marital Status: **Single** **Married** **Divorced** **Widowed**

Email Address (for appointment reminders/confirmations): _______________________________________

Referral Information: **Internet** **Advertisement** **Patient/ Name:**_______________________________

Referral office/ Name:______________________________

Other:___________________________________

Responsible Person for Account Information

Person Responsible for Account/Relationship to Patient:____________________________________

Birth Date:____________________________ **SSN:**____________________________________

Home Ph #______________________ **Work Ph #**_____________________ **Cell Ph #**___________________

Employer:_______________________________________

Business Street Address:_______________________________________

City:____ **State:**_____________ **Zip:**___________________

Primary Dental Insurance Information (*Secondary Insurance Claim Filing will be patient's responsibility*)

Subscriber/Policy Holder's Full Name:_______________________________________

Birth Date:_________________________________ **SSN:**____

Employer:_______________________________________ **Work Ph #**______________________________

Name of Insurance Company:______________________________ **Customer Service Ph#**________________

Member ID#____________________________________ **Group #**________________________________

If patient is a full-time college student, name and city/state of school:_______________________________________

Patient Medical History

We are concerned with your total well-being, not just your oral health. Please complete the following health questions completely so that we may better serve your health needs.

Do you have or have you ever had any of the following:

Hypoglycemia or diabetes	Facial or Head Injuries	Mitral Valve Prolapse	Stroke
Circulatory Problems	Nervous Disorders	Fainting, Blackouts	Chest Pains
Blood Transfusions	Excessive Bleeding	Kidney Problems	Thyroid Problem
Sinus Problems	Neck Injuries	Glaucoma, Eye Problems	Other_______________
Anemia, Blood Disorder	Headaches, Migraines	Allergies (seasonal)	
AIDS, Positive HIV	Joint Replacement / Implant	Eating Disorders	
Ulcers, Digestive Problems	Hay Fever / Asthma	High Blood Pressure	
Cardiac Pacemaker	Lung Problems / Tuberculosis	Epilepsy, Seizures	
Heart Attack / Heart Trouble	Radiation Treatments	Malignancies, Cancer	
Hepatitis, Jaundace	Heart Murmur	Rheumatic Fever	

Please provide details concerning any of the above conditions: ____

Please list any current medications that you are taking: ____

Have you been hospitalized in the last two years? If yes, please explain: ____

Are you allergic to any of the following?

Aspirin   Penicillin   Codeine   Acrylic   Metal   Latex   Local Anesthetics

Other   If yes, please explain: ____

Women: Are you…   Pregnant/Trying to get pregnant?   Nursing?   Taking oral contraceptives?

Have you noticed any of the following:

Teeth tender to chewing	Discomfort in face, head, neck	Food caught between teeth	Bleeding or sore gums
Sensitivity to sweets	Jaw clicking or popping	Sensitivity to hot or cold	Swelling, lumps in mouth
Recurring sore in mouth	Recurring sore around mouth		

Tell us, in your opinion, what is the present state of your oral health? ____

What are your expectations from our office? ____

Guarantee of Account – Office Protocol

For those with dental insurance, as a courtesy, we will assist you in processing your insurance claims. Your co-payment amount is due when services are provided. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. Please be aware that some and perhaps all services provided may be "non-covered" services and not considered reasonable and necessary under your insurance.

I guarantee full payment of all dental charges incurred by the above patient.

Signed: ____   Date:_________________________

I give my consent to needed dental services recommended for my benefit (or for my minor) and accept full responsibility of services performed.

Signed: ____   Date:_________________________

I understand that if I fail to keep my appointments without prior notification of 24 hours, a $50.00 broken appointment fee will be charged for which I accept full responsibility of payment.

Signed: ____   Date:_________________________

I understand that account balances beyond 60 days will incur service charges for which I accept full responsibility of payment.

Signed: ____ Date:_________________________