



Welcome to our office! We would like to get to know you better to enable us to help you attain optimum oral health and provide you with a fantastic dental experience with the utmost care. To do so, we ask that you provide us with some confidential information about yourself.

PERSONAL INFORMATION

Name _____
Address _____
City _____
Home Phone _____
Cell Phone _____
Email _____
DOB _____
SS # _____

TODAYS DATE _____

Occupation _____
Employer _____
Dental Ins. _____
City _____ State _____ Zip _____
Ins. Phone _____
Subscriber's Name _____
Group # _____
Subscriber ID # _____
Subscriber's Employer _____

EMERGENCY CONTACT

Name _____
Address _____
City _____ State _____ Zip _____
Contact Phone _____

Whom may we thank for referring you?

HEALTH INFORMATION

Please indicate the following if you have a history or have presently by checking the corresponding box:

<input type="checkbox"/> Heart Attack or Stroke	<input type="checkbox"/> Kidney or Liver problems	<input type="checkbox"/> Anemia or Sickle Cell Disease
<input type="checkbox"/> Heart Disease or angina	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Bruise easily
<input type="checkbox"/> Heart pacemaker	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Radiation or chemotherapy
<input type="checkbox"/> Heart surgery/artificial valve	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma or emphysema	<input type="checkbox"/> Epilepsy or seizures
<input type="checkbox"/> Artificial joints (hip, knee...)	<input type="checkbox"/> Hepatitis B C or D	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Arthritis or steroid medication	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Substance abuse or addiction
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Allergies or hives (other than seasonal)
<input type="checkbox"/> Fainting or dizzy spells	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Cancer (of any type)
<input type="checkbox"/> Congenital Heart Disease, Heart Murmur, Mitral Valve Prolapse or history of Rheumatic Fever		

Physician's Name _____
Physician's Address _____

Phone Number _____
Last visit _____

Are you currently taking any medications? _____

Do you pre-medicate prior to dental visits? _____

Do you have any disease or condition not listed? _____

Women Are you pregnant? _____ Nursing? _____ Birth control? _____

DENTAL INFORMATION

In a sentence, what do you expect from our office? _____

Are you having any dental pain? _____ If so where? _____

When was your last dental visit? _____ When did you last have x-rays? _____

Would you like your teeth whiter? _____

Do you have concerns about your smile? _____

Do you clench or grind your teeth? _____

Do you floss? _____ How often? _____

Do your gums bleed when you brush? _____

Do you snore or has anyone ever told you that you snore? _____

Do you have bad breath? _____

Do you get cold sores or ulcers? _____

Do you smoke? _____ How many packs per day? _____

Do you have latex or drug allergies? _____

Do you have any other allergies (including non dental related?) _____

FINANCIAL INFORMATION

Full payment is expected at the time of service and a courtesy discount is offered for payment in full to all out-of-network participants. As a courtesy, we will file your insurance claim electronically for you with your primary carrier. We will do our best to provide you with an **estimate** of your plan benefit; however, *the patient is responsible for knowing all co-pay, deductible and maximum benefit information prior to all visits.*

By signing this document, I, the undersigned authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient’s dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the under signed, and further authorize and consent that the Doctor choose and employ such assistance as deemed fit. I understand there are certain risks involved with anesthetics, and that many dental procedures are surgical procedures and carry risks that can permanently cause damage to the patient.

I also understand that payment of my bill is my legal obligation. All filling of insurance and confirmation of insurance payments to be made by my insurance company are my sole responsibility. Any assistance concerning these matters granted by this office is strictly given as a courtesy and implies no responsibility on their part for filing, follow-through or confirmation. If this account is placed with an attorney or collection agency, I agree to pay attorney fees of 33.3% of the unpaid principal and interest owing, plus all court costs and interest in the amount of 1.5% per month beginning 60 days after the account as become due. I further agree to pay return check charges of \$25 per returned check. I understand that all the above confidential information is true and correct to the best of my knowledge and will help provide the best dental care for me.

Signature of Patient _____ Date _____

Witness _____ Date _____