Livingston Dental Arts, LLC

Date__________________ Email_____________________________________

Last___________________ First____________________ Dr. Mr. Mrs. Ms.

Married______ Single______ Divorced______ Other______

Address,City , State&Zip____

Home( )_____-__________ Work( )_____-__________ Cell( )_____-________

Family or friends seen by the office____

Social Security#________-________-_________ Birth Date____/____/____

Employer_______________________________ Occupation___________________________

Whom may we thank for referring you?____

Physician Name__________________________ Phone( )________-________________

Address,City, State&Zip____

Credit Card____________-_____________-______________-____________ exp____/_____

This credit card will be used to reserve all appointments scheduled. Each appointment is reserved exclusively for you. There is a cancellation fee for appointments not cancelled with 24 hours notice. This credit card will be used for cancellation fees and balances not covered by insurances. Please sign here in **Acknowledgment.**

X_________________________

Dental Insurance

Insur. Co._____________ Phone( )_______-___________Group/Policy#__________

Insur. Name______________S.S.#________-________-_______ DOB_____/_____/_____

Insued Employer__________________________ self______spouse______child_______

Authorization

I certify that I am covered by insurance and I assign directly to Livingston Dental Arts,LLC all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any monies that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure payment of benefits. I authorize the use of my signature on all my insurance submissions.

SignatureX____ Date________________

Are you currently having discomfort?	y n	Do your gums bleed?	y n
Discomfort in jaw joint(TMJ/TMD)?	y n	History of periodontal disease?	y n
Are your teeth sensitive?	y n	Would you like a brighter smile?	y n
Are you a smoker?	y n	Are you pregnant?	y n

Medical History

Please list medications you are taking

Please list known allergies

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

*Do you require antibiotics before any dental treatment? y n Medication______________

Abnormal Bleeding	y n	Congenital Heart Defect	y n	Headaches	y n
Liver Disease	y n	Alcohol Abuse	y n	Mitral Valve Prolapse	y n
Artificial Joints	y n	Low Blood Pressure	y n	Epilepsy	y n
Sinus Problem	y n	Heart Surgery	y n	Heart Murmur	y n
Stroke	y n	Drug Abuse	y n	Osteoporosis	y n
Hepatitis A B C	y n	Artificial Valves	y n	COPD	y n
Thyroid Problems	y n	Seizures	y n	Herpes	y n
Asthma	y n	Anemia	y n	Cancer	y n
HIV/AIDS	y n	Ulcers	y n	Blood Disorder	y n
Kidney Problems	y n	Chemotherapy	y n	Tuberculosis	y n
Radiation Tx	y n	Psychiatric Tx	y n	High blood Pressure	y n
Heart Attack	y n	Diabetes I II	y n	Pacemaker	y n

Other______________________________

Emergency Contact

Name______________________ Phone( )________-__________

Consentfor examination,x-rays,notice of Privacy Practice (HIPPA)

To the best of my knowledge, the above information is correct. I authorize examination, taking of x-rays,photographs and treatment recommendations by the attending dentist. I have the right to review and/or receive the Notice of Privacy Practice and may request a copy from the front desk.

Signature**X**____ **Date**__________