



Welcome To Our Practice

Date _____

Patient Information

Name _____ Birth Date _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Address _____

Employer City _____ State _____ Zip _____

Name of Person Responsible for this Account _____ Drivers License No. _____

Responsible Party's Address (if different from above) _____

Home Phone _____ Work Phone _____ Ext. _____ Cell _____

Emergency Contact _____ Phone # _____ Relationship _____

Whom May We Thank For Referring You? _____ Email: _____

Insurance Information

Name of Insured _____ Birth Date _____ Soc. Sec. # _____

Relation To Patient _____ Address _____

City _____ State _____ Zip _____

Employer _____ Address _____ Date Employed _____

Insurance Group # _____ Do You Have Dual Insurance? If Yes, Please Provide Copy Of Insurance Card.

Dental/Medical History

Reason for today's visit _____ Date of last dental visit _____ Date of last X-rays _____

Check if you have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin, Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any serious illnesses or operations? Yes No If yes, please describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

Are you allergic to Latex? Yes No Please list any other allergies _____

(Women) Are you Pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Do you require antibiotics before a dental visit? If yes, please list: _____

List medications you are currently taking and the correlating diagnosis: _____

Are you allergic to any medications? Please list _____

Are you or have you taken any of the following medications (bisphosphonates) for Osteoporosis?

Yes No	Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Didronel	<input type="checkbox"/> <input type="checkbox"/> Actonel	<input type="checkbox"/> <input type="checkbox"/> Boniva	<input type="checkbox"/> <input type="checkbox"/> Zometa
<input type="checkbox"/> <input type="checkbox"/> Fosamax	<input type="checkbox"/> <input type="checkbox"/> Aredia	<input type="checkbox"/> <input type="checkbox"/> Bonafos	<input type="checkbox"/> <input type="checkbox"/> Skelid

If you answered yes to any of the above, how long have you taken the medication? _____

Please check if you have had any of the following:

Yes No	Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> <input type="checkbox"/> Cough up Blood	<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> <input type="checkbox"/> Skin Rash
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Swelling of Feet or Ankles
<input type="checkbox"/> <input type="checkbox"/> Back Problems	<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Tobacco habit
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Tonsillitis
<input type="checkbox"/> <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Heart Problems	<input type="checkbox"/> <input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> <input type="checkbox"/> Ulcer
<input type="checkbox"/> <input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease

Authorization and Release

Our office is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. It must be clearly understood that the insurance “contract” is between you, the patient, and the insurance company. Therefore, you are responsible for any amount not paid by the insurance company. Although we are willing to complete insurance information forms and submit a claim on behalf of the patient, we do not accept responsibility—under any circumstance—for the outcome of the transaction. Completing insurance forms is a courtesy we extend to our patients in an effort to maximize their likelihood of obtaining insurance reimbursement. By having our office process insurance forms, the patient agrees to accept liability for those forms. Alternatively, a patient may fill out his/her own insurance forms and bill the insurance directly. The patient will pay the *estimated* co-payment (the amount not covered by the insurance company) at the time services are rendered. ***This is an estimate only***, and this amount may change based upon final insurance company payments. Our office does NOT guarantee that the patient’s insurance company will pay for any procedure. You are responsible for any amount not paid by the insurance company. For any treatment, including dentures, partials, crowns/bridges, your full co-payment will be due at the first visit. **For patients without insurance, full payment is due the day of treatment (including treatment for dentures, partials, crowns/bridges).**

I have read and answered the above questions to the best of my knowledge and agree to all of the above office policies. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient/responsible party

Date