PATIENT INFORMATION: Today's Date_____

Last Name_____ First Name _____Mid _____

Address _____ City, ST _____ZIP_____

Home Phone # _____Bus. Phone # _____Cell #_____

Patient Employer _____Bus. Address _____

Patient Social Security #_____Email _____

Date of Birth:_____

SPOUSE/PARENT/GUARDIAN INFORMATION: **(Circle One)**

Name _____

Address if Different _____ City, ST _____ZIP_____

Home Phone #_____Bus Phone # _____ Cell # _____

PRIMARY DENTAL INSURANCE INFORMATION:

Subscriber Name_____

Ins. Co. Name _____

Ins. Co. Address _____

City, ST, Zip _____

Group Policy # _____

Subscriber SS # _____

Subscriber Date of Birth _____

SECONDARY DENTAL INSURANCE INFORMATION:

Subscriber Name_____

Ins. Co. Name _____

Ins. Co. _____

City, ST, _____

Group Policy # _____

Subscriber SS # _____

Subscriber Date of Birth _____

Assignment & Release: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records can be used by the dentist if he so determines.

In consideration of the service rendered, I am obligated to pay this office in accordance with its credit terms and policy.

I consent to the taking of photographs and X-Rays before, during and after treatment, and to the use of same by the dentist in scientific papers or demonstrations. I certify that I have read or had read to me the complete contents of this form.

I agree to the above: Signature_____ Date _____
(Parent or Guardian if patient is a minor)

What method of payment will you be using today? ___ Cash, ___ Check, ___ Visa, ___ Mastercard, ___American Express, ___Discover or ___Outside Dental Financing Plan (Care Credit and Capital One)

Referring Dentist _____**Phone #** _____

PATIENT HEALTH HISTORY:

Physician Name _____**Phone #** _____

Please Circle Yes or No to the Following Questions. Please write in any necessary details.

1. Are you in good health? Yes No

2. Have you been seen by a physician in the last 5 years? Yes No

3. Are you sensitive or allergic to Novocain, Penicillin, Sulfa,

Codeine or other medication? Yes No

4. Are you taking any medication now? Yes No

5. Have you ever had excessive bleeding requiring special treatment? Yes No

6. Have you ever had an unfavorable reaction following dental treatment? Yes No

7. Has your doctor told you premedication is required prior to dental treatment due to

a heart condition, joint replacement, or any other condition? Yes No

8. Have you ever had any of the following illnesses? (Circle those that apply) Yes No

Stroke, Heart Trouble, High Blood Pressure, Rheumatic Fever, Asthma, Tuberculosis,

Hepatitis, Jaundice, Kidney Trouble, Diabetes, Epilepsy, Nervous Disorder,

Mitral Valve Prolapse, Latex Allergy.

9. Do you have AIDS ? (Acquired Immune Deficiency Syndrome) Yes No

10. Do you have ARC? (AIDS Related Complex) Yes No

11. Female Patients: Are you Pregnant? If Yes: What Month _____ Yes No

List Medications you are taking or details about your health history: _____

_____

_____

The above medical history is accurate. I, the undersigned, consent to the performing of any procedure necessary to evaluate, diagnose and treat my condition. I authorize and request the administration of drugs and/or anesthetics as may be deemed advisable by the dentist.

Patient Signature _____Date _____

(Parent or Guardian if patient is a minor)