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**About You**

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Parent /Guardian, if minor: \_\_\_\_\_

Status: Single Married Divorced Widow(er) M F

Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

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**Insurance Info.**

**Primary Dental Insurance**

Insured's Name: \_\_\_\_\_

Insured ID#: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ / \_\_\_\_\_

Group # \_\_\_\_\_

**Secondary Dental Insurance**

Insured's Name: \_\_\_\_\_

Insured ID#: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ / \_\_\_\_\_

Group # \_\_\_\_\_

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**Office Financial Policy**

**Cash Patients:** Payment is due on the day of services rendered- via cash, check or credit card.

**Insurance Patients:** We'll calculate the amount insurance will cover, and the amount that is your responsibility including any deductible. Then you can pay your portion the same day by cash, check or credit card. *Reduction or rejection of your claim by your insurance company means you're still responsible for the charges incurred in your account.*

Our office reserves the right to charge for missed or broken appointment. We request that you give us **24-hour notice** if it becomes necessary for you to reschedule your visit.

\_\_\_\_\_ I hereby authorize assignment initials of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

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**Emergency Contacts**

Whom shall we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who is your Medical Doctor: \_\_\_\_\_

Doctor's Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PLEASE CONTINUE ON BACK**

Please list all medications you are currently taking (including birth control pills, over the counter meds such as vitamins, herbal remedy, aspirin, etc.)

Medicine	Dosage	Reason or Condition
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Do you have or have you had any of the following diseases, medical conditions or procedures? (circle)

Y N Heart attack/Stroke	Y N Thyroid Problems	Y N Cancers/Tumors	Y N Cosmetic surgery
Y N Heart Surg./Pacemaker	Y N Kidney Problems	Y N Shingles	Y N Xray or Cobalt Treatmt
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral valve prolapse	Y N Sinus Problems	Y N Arthritis/Rheumatism	Y N Difficulty breathing
Y N Artificial Valves	Y N Stomach Problems/Ulcers	Y N Artificial bones/joints	Y N Diabetes
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital heart defect	Y N Venereal Disease	Y N Fainting/seizures/epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Frequent Headaches	Y N Bleeding Problems
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Glaucoma/Cataracts
Y N High/Low Blood Pressure	Y N Jaw Pain TMJ/TMD	Y N Back Problems	Y N Nervousness

Please list any other surgeries or medical conditions you have or ever had: \_\_\_\_\_

Are you allergic to any of the following (circle): Latex Penicillin/Amoxicillin Tetracycline Aspirin  
 Do you use tobacco? Y N / How used \_\_\_\_\_ How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Have you ever taken/taking the drugs

1. Phen-Fen and/or Redux? N Y /If so, have you seen your doctor since? Y N
2. biphosphonate medicines (Fosamax, Actonel, Aredia, Zometa, etc.) Y N

**WOMEN:** Are you taking birth control pills? Y N Pregnant? Y N Nursing? Y N Menopause? Y N

Do you usually take **premedication** before dental appointment (i.e. antibiotics)? Y N \_\_\_\_\_

\*I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

\*I understand the above information is completed to the best of my knowledge, and will inform this office of any changes. All the information provided will be kept confidential.

**SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_