Please complete the following confidential information

Today's Date_____
Patient Name_____ Nickname, if any _____
Email: (Where your records are sent) _____
Street Address _____
City_____ State_____ Zip_____
Birth date_____ Gender_____ SSN_____
Home Phone_____ Cell Phone_____ Work Phone_____
Emergency Contact – Name_____Phone#_____

Health History

How do you prefer to receive your appointment confirmations? (Check mark your choices)
Home Phone___ Cell Phone___ Work Phone___ Text Message___ Email___
Single___ Married___ Widowed___ Divorced ___Child___
How did you hear about our office? _____
If referred, whom can we thank for referring you? _____
Reason for leaving previous dentist _____
What did you like most about your previous dentist? _____
What is your chief dental complaint today? _____ _____ What is your ultimate goal with your dental healthcare?_____
Are you in good health? Yes___No___ Date of last physical exam _____

Physician's Name: _____

Address: _____ Phone: _____

Are you currently under the care of a physician? Y___N___

Have you been hospitalized in the last 5 years or had a serious illness? Y___N___

If yes, please explain: _____

Please list any medications, drugs, or pills you are currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Are you allergic to or have you had an adverse reaction to the following medications? (Please circle)

Aspirin Penicillin Local Anesthetic Codeine Other Antibiotics

Are you allergic to any other medications or substance? _____

Are you on Medication Bone Replacement therapy (i.e. Fosamax)? Y___N___

Please check if you have ever had any of the following:

__Heart attack	__Heart trouble	__Heart Murmur	__A Stroke
__High Blood Pressure	__Rheumatic Fever	__Bleeding Problems	__Blood Transfusion
__Tumor or Growth	__X-Ray Treatment	__Arthritis	__Asthma
__Kidney Disease	__Glaucoma	__Tuberculosis	__Ulcers
__Jaundice	__Epilepsy	__Hepatitis	__Diabetes
__Anemia	__Convulsions	__Venereal Disease	__AIDS
__Herpes	__Cancer	__Hepatitis B or C	__Sleep Apnea

__Joint Replacement -If yes, when_____
(CONTINUED)

Do you smoke? Y___N___ If yes, how much do you smoke? _____
Are there any other diseases or conditions not listed that we should know about?
_____

FOR WOMEN ONLY:

Are you pregnant? If so, how far along? _____
Are you taking birth control pills? Y___N___

ACCOUNT INFORMATION:

Person responsible for account/relationship to patient_____
Birth date _____ Phone Number _____
Spouse's Name _____ Birth date _____ Phone _____

DENTAL INSURANCE:

Insurance Carrier _____
Subscriber/Member Name_____ Subscriber/Member ID _____
SSN _____ Birth date _____
Employer _____ Group Number _____

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or other diagnostic aids deemed necessary to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any treatment, medication, or therapy that may be indicated in connection with (Patient Name) _____. I understand that I will be informed of the treatment and any costs if requested, before it is started. I further authorize and consent the Doctor to choose and employ such treatment as he/she deems fit.

I understand the use of anesthetic agents embodies a certain risk.

Signature _____ **Date** _____
Relationship to Patient _____
If you are interested in payment plans for your dental treatment please inform someone at the front desk when checking out.

OFFICE PAYMENT POLICY:

Full payment for services rendered is expected at **time of service.** We accept Cash, Check, Credit/Debit Card, and Care Credit.

On all insurance cases, we expect estimated payment in full to the office and we will assist you in recovering as much as you can get according to your insurance carrier. If your insurance carrier does not pay what we estimate, you will be billed the remaining balance and will be expected to pay that balance within 60 days to avoid a finance charge. If they pay more than we estimate, you may either have a credit on your account or, at your request we can mail you a check for the credit.

Patients will be responsible for any attorney fees and additional collection handling fees if necessary to collect unpaid accounts, including Finance Charges. I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other payment arrangements have been made with our office.

I fully understand the above policy and will abide by it.

Signed _____