

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Gender: _____ Date: _____
 Social Security #: _____ Birth Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (Home) _____ (Cell:) _____ (Work): _____
 Employer: _____ Occupation: _____
 Email Address: _____

Health Information

Date of Last Dental Visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers |
| _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Neck or back pain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | |

• Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____

• Are you taking any Prescription Medications? Yes No
 If yes, please explain: _____

• Women only: Are you currently pregnant? Yes No Due Date: _____

• Is there a special occasion coming up that you would like to improve your smile for? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

 Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
 Name of person or office referring you to our practice: _____

Responsible Party Information (if other than patient)

Name: _____ Relationship to Patient: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Home Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ Patient's relationship to insured: Self Spouse Other _____

Insured's Employer Name: _____

Address: _____

Insurance Name : _____ ID#: _____ Group#: _____

Insurance Address: _____

Insurance Phone Number: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ Patient's relationship to insured: Self Spouse Other _____

Insured's Employer Name: _____

Address: _____

Insurance Name: _____ ID#: _____ Group#: _____

Address: _____

Insurance Phone Number : _____

Consent for Services

Our practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are ONLY an ESTIMATE on what the insurance company will cover. The patient is responsible for ANYTHING the insurance company DOES NOT cover, as our office submits the dental claim as a courtesy to our patients. **The Patient's portion will be collected the day services are rendered.** Our office DOES not offer in house payment plans.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Guarantor of Payment/Responsible Party _____ Relationship to Patient: _____ Date: _____