



We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL INFORMATION

Patient Name Last First MI (Preferred)
Date of Birth SS# DL# Gender: [] M [] F Married: [] Y [] N
Address City State Zip
Home Phone Mobile Phone Email
Current Employer Employer Phone #
How did you hear about us? [] Mailer [] Drive By [] Google [] Friend/Patient [] Other
Preferred Appointment Confirmation Type: [] Text Message [] Phone Call [] Email
When was your last dental visit?
Reason for today's office visit?
Interested in teeth whitening? [] Yes [] No Interested in a straighter smile? [] Yes [] No Snore at night? [] Yes [] No

If patient is under 18 yrs, please also complete the following:

Guarantor Name Last First MI (Preferred)
Date of Birth SS# DL# Gender: [] M [] F Married: [] Y [] N
Address City State Zip
Home Phone Mobile Phone Email

INSURANCE POLICY INFORMATION

Patient relationship to subscriber: [] Self [] Spouse [] Child **PLEASE PRESENT YOUR DENTAL ID CARD**
Subscriber Name Sub.ID # Sub.DOB
Insurance Company Phone
Employer Group Name Group #
Is patient covered by another insurance? [] Y [] N

NO SHOW & CANCELLATION POLICY

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you. We ask that if you must change an appointment, please give us at least 48 hours notice. This courtesy makes it possible to give your reserved room to another patient on our waiting list, who would like it.

Save Dental charges \$50.00 per hour for any no show or late cancellation of an office visit or hygiene visit. I understand that repeated cancellations or missed appointments will require me to pre pay (\$50.00 per hour) for the appointment upon scheduling. I understand that if I fail to show up for my scheduled appointment or cancel less than 48 hours that pre paid amount becomes nonrefundable.

Initials

MEDICAL HISTORY

Name of Medical Doctor _____ City/State _____

Emergency Contact _____ Phone _____ Relationship _____

List all medications or drugs you are now taking:

None

Check medications or drugs you are allergic to:

None Local Anesthetics
 Aspirin Metals
 Codeine/ Other Narcotics Penicillin
 Erythromycin Sulfa Drugs
 Latex Rubber Other _____

Check any medical conditions you may have:

<input type="checkbox"/> None	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Joint Replacement, Date of _____
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney/Bladder Trouble
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Anemia/Leukemia	<input type="checkbox"/> Fainting Spells/Seizures	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Fever Blisters/Herpes	<input type="checkbox"/> Mental Health Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Asthma/Hay Fever	<input type="checkbox"/> Frequently Dry Mouth/Sjogren	<input type="checkbox"/> Persistent Diarrhea
<input type="checkbox"/> Blood Clotting Problems	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Rheumatic Heart Disease
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease/Angina	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Cancer/Tumor or Growth	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Cardiac Pacemaker	<input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Chest Pain Upon Exertion	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Damaged Heart Valve	<input type="checkbox"/> Hives/Skin Rash	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other _____		

Unusual reaction to dental injections or general anesthesia? Yes No

Does your doctor recommend you take pre-med with antibiotics prior to any dental treatment? Yes No

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? Yes No

Tobacco use? Yes No What kind & how much _____ Do you use recreational drugs? Yes No

Patient Agreement

Our office provides insurance billing as a courtesy to our patients. The patient portion of dental services is **estimated only** and not guaranteed. All patient portions are due at the time of service. This amount may be subject to adjustment when claims are adjusted by the insurance company. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance company. I understand that I am solely responsible for monitoring my insurance plans limitations, coverage and benefits and it is not the responsibility of my dental care provider. I acknowledge that I am responsible for any and all balances due. If sent to collections, I agree to pay a 40% fee, all attorney fees, interest (1.8% monthly), and court costs accrued as a result of past due balances.

I agree to being contacted by phone, text messages or emails, using the information I have provided. I agree and understand that these methods of contact may be used in an attempt to collect any amounts owed, for scheduling and billing messages, or for other information deemed relevant to my patient care.

By signing below, I certify that all of the above information is true to the best of my knowledge.

I have read and received a copy of this office's Notice of Privacy Practices.

Patient/Guardian Signature _____ Date _____