TO THE PATIENT: PLEASE COMPLETELY FILL OUT SECTIONS 1, 2 & 3, SIGN AND DATE WHERE INDICATED.

SECTION 1

Patient Information

Date:___________________________

Name:____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female
Last *First* *M*

Birth Date: _____/_____/_____ SS# _________-________-_________Drivers License Number:______________________________

Address: ____
Street *Apt #* *City* *State* *Zip*

E-Mail Address______________________________________ Phone – Home:_______________________________________

Phone – Work: _____________________________ Ext. ________ Time to Call: ___________ Cell: _________________________

Place of Employment ____Occupation/Position_____________________

If Full time Student, School Name:____ Grade_____________________

Medical Insurance Company:___________________________________ID#__________________ Group # ___________________

Dental Insurance Company:____________________________________ ID#__________________ Group # ___________________

Has any member of your family been treated in our office? ☐ Yes ☐ No Local #_____________________

Whom may we thank for referring you to our office? ____

Insured Information

☐ ***Father*** ☐ ***Husband***

Last *First* *M*

Street *City* *State* *Zip*

Home # *Work #*

Birth Date (Mo/Day/Year) *SS#*

Employer *Drivers License #*

Dental Insurance Co. *Group #*

☐ ***Mother*** ☐ ***Wife***

Last *First* *M*

Street *City* *State* *Zip*

Home # *Work #*

Birth Date (Mo/Day/Year) *SS#*

Employer *Drivers License #*

Dental Insurance Co. *Group #*

Emergency Information

Outside of Immediate Family/Household

Name ____

Address ____

City/State/ZIP ______________________________________

Telephone # ____

Responsible Party

Responsible party currently is a patient of record at this office ☐ Yes ☐ No

Method of Payment:
Patients will be expected to pay for services when treatment is rendered.
Visa/MasterCard are accepted.
☐ I wish to discuss interest free financing with Care Credit

If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Professional care is provided ***to you, our patient, and not to an insurance company***. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and in handling insurance questions from our office on your behalf. However, insurance balances 60 days and over are ***due in full from the patient***.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I realize a responsible adult (parent or guardian) must remain in the office while treating a minor.

In connection with dental services which I am receiving, I consent that photographs, audio, and/or video recording may be taken of me, for the explicit use of dental research, education, training or science; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name. I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or other showing of the photographs/video tape regardless of whether such use of said photographs/video tape is commercial, institutional or private sponsorship, and irrespective of whether any fee or charge is received.

Initials: ____ Date: ______________________________

☐ Adult Patient ☐ Father ☐ Husband ☐ Mother ☐ Wife ☐ Guardian

SECTION 2

Medical History

	Yes	No
Are your under a physician's care now? Why? Who? ______	☐	☐
Date of last physical exam ______		
Have you ever been hospitalized or had an operation? Describe ______	☐	☐
Have you ever had a serious injury to your head or neck? Describe ______	☐	☐
Are you taking any medications, pills or drugs? (Include illegal/recreational drugs) What? ______	☐	☐
Are you on a special diet? Describe ______	☐	☐
Are you allergic to any medications or substances? Please check box for allergic reaction below ______	☐	☐

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other ______

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Describe______

Do you have or have you ever had any of the following:
(*If yes to any of the * starred conditions, please call prior to your appointment...premedicatons may be required)

	Yes	*No*		*Yes*	*No*		*Yes*	*No*		*Yes*	*No*
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Radiation Therapy	☐	☐	Thyroid Disease	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problems)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐
Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐
Scarlet Fever*	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problems	☐	☐	Diabetes	☐	☐	Artificial Joints*	☐	☐
Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐
Heart Surgery*	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS*	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A & C (Infectious)	☐	☐	Herpes (Cold Sore)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B (Serum)	☐	☐	Drug Addiction/Use	☐	☐
Alcohol Use/Abuse	☐	☐	Fever Blisters	☐	☐	Hepatitis C	☐	☐	Genital Herpes	☐	☐
Depression	☐	☐	ADD/ADHD	☐	☐	Stroke	☐	☐	Snoring / Sleep Apnea	☐	☐
						Seizure	☐	☐			

Have you ever had any other serious illness not checked above? Describe ______	☐	☐
Do you wish to talk to the dentist privately about any problem? ______	☐	☐

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that I am taking.
In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you can get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST: ☐ ***I DO WANT A COPY OF 'NOTICE'*** ☐ ***I DO NOT WANT A COPY OF 'NOTICE'***

______ Date: ______

☐ *Adult Patient* ☐ *Father* ☐ *Husband* ☐ *Mother* ☐ *Wife* ☐ *Guardian*

Reviewed by Doctor ______ Date ______ BP ______

History review and significant findings: ______

Medical History Update

Date	Comments	Signature
______	______	______
______	______	______
______	______	______