WELCOME

Thank you for selecting our office for your dental needs.
To help us meet your healthcare requirements please fill out this form completely.
If you have any questions or require assistance, please ask us…we'll be happy to help!

- **Personal Information**

Name: ___________________________________ Date of Birth: _______________ SS#: _____________________

Male: _____ Female: _____ Married: ____ Single: ______Child: _____Other: _____

Address: ____

City: ______________________________State: _______ Zip: ___________ Home Phone: ______________________

Employer: ___________________________ Work Phone: ______________ Cell Phone: ______________________

Occupation: __________________________ Email Address: ____

Referred By: ____ Relation: __________________________________

- **Responsible Party**

Name: ____________________________________ Date of Birth: ____________ SS#: ________________________

Employer: ____________________________________ Work Phone: _______________________

Relation to Patient: ________________________

- **Insurance Information**

Insured's Name: ______________________________________ Insured's Date of Birth: ________________________

Insured's SS#: ________________________________ Insured's Employer: ______________________________

Insurance Company: ___________________________ Group#: ________________________

- **Dental History**

Date of last Dental Exam: _______________________ Date of Last Pano/Full Mouth X-ray______________________

Any serious problems associated with previous dental treatment? ____

Name and number of Previous Dentist: ____

If for any reason you need to reschedule your appointment, we require at least a 48 hour notice.
Due to the high demand for appointments, there will be a $50 charge for Failed Appointments.

(PLEASE SEE REVERSE)

Medical History

It is important that we know your medical history as it has a direct bearing on you dental health. This information is strictly confidential and will not be released to anyone. Thank You!

***Please circle if you have had or presently have any of the following:**

Heart Disease/Surgery	Artificial Joints-(hips,knee,other)		Chemotherapy
High Blood Pressure	Stroke	Arthritis	Radiation Treatment
Congestive Heart Failure	Anemia	Diabetes	Kidney Problems
Artificial Heart Valve	Glaucoma	Liver Disease	Hepatitis A, B, C
Pacemaker/Defibrillator	Asthma	Alcoholism	AIDS/HIV Positive
Heart Murmur/MVP	Endocarditis	Drug Addiction	Herpes Type 1 or 2
Mental Health Problems	Tuberculosis	Rheumatic Fever	Thyroid Disease
Abnormal Bleeding	Epilepsy/Seizures	Other Not Listed:____________________________	

***Are you allergic to any of the following?**

Latex
Aspirin
Local Anesthetic
Codeine
Penicillin
Erythromycin
Sulfa Drugs
Other: ______________________________

Do you have any condition or problem Not listed we should know about?
____

Do you have any current health problems?
____

What medications are you currently taking?

____

Are you pregnant or nursing? _______

Do you use tobacco? __________

Name of Physician: ____________________________
Number: _________________________________

In the event of an emergency, whom should we contact? ____

*As a **courtesy** to our patients, we do file and accept assignment for your insurance.*
Please remember that your insurance is a contract between you, your employer and the insurance company. ***We are not a party to this contract.*** *We will estimate your out-of-pocket expenses based on information that your insurance company provides us: however, insurance carriers will not guarantee their information.* ***You are responsible for all fees for services that are performed.*** *If insurance has not paid the full balance of the claim within 60 days, you will be responsible for the balance. We recommend that any questions regarding your insurance company's coverage of treatment be addressed directly to the insurance company or your employer.*

Patient Signature: ____ **Date:** ______________________

Dentist Signature: ____ **Date:** ______________________