Date:

GETTING TO KNOW YOU AS OUR PATIENT

Patient name	Birthdate	Social Security Number	Home Phone ( )
Marital Status: ___ Single ___ Married ___ Divorced ___ Separated		___M ___F	Driver's License and State
Primary Insurance Company _____		Group _____	Subscriber _____
Secondary Insurance Company _____		Group _____	Subscriber _____
Responsible Party			
Name		Social Security Number	Home phone ( )
Home Address		City, State, Zip	Birthdate
Marital Status: ___ Single ___ Married ___ Divorced ___ Separated		Relationship To Patient	Driver's License and State
Responsible Persons' Employer		Occupation	Work Phone ( )
Business Address		City	State Zip
Spouse's Name		Social Security Number	Birthdate
Spouse's Employer		Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address		**Email:**	

How did you hear about our office?
(Check only one)

___ Referred by a Friend ___ Yellow Pages ___ Relative ___Insurance Plan ___Welcome Wagon

___ Other_____ ___ TV/Radio AD ___ Newspaper AD ___Direct Mailing ___Sign by Building

If you were referred, whom may we thank for referring you? _____

CONSENT

• I will answer all health questions to the best of my knowledge._____
(Initial)

Alter explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary by the doctor

_____ _____

• Signature Date Relationship to Patient

AGREEMENT TO PAY

I agree to pay for all services rendered. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. I also understand in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be responsible to pay up to the agreed upon fee schedule.

Payment Preference: ___Cash / Check on day of treatment ___ Credit Card ___ Debit Card

_____ _____

• *Signature* *Date*

There may be a charge for any missed appointment not cancelled 24 hours before the appointment time.

PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, ect.)_____
Previous Dentist _____ Last Visit _____Date of Last Cleaning_____
Have you had any problems with past dental treatment? _____
Are you nervous about seeing a dentist? (Y) (N)
How often do you brush? _____ Do you floss? (Y) (N)
(please circle each)

Y N I clench or grind my teeth during the day or while sleep.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.

How often? _____

Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straighter.
Y N I want my teeth whiter.

What are your dental priorities?_____
(e.g.: appearance, dental health, financial considerations, etc)

PATIENT'S MEDICAL HISTORY

I consider my health to be (Please check one): ___Excellent ____Good ___ Fair ____ Poor

Do you have or have you had any of the following? Please circle Y for yes N for No.

1. Y N Heart disease
2. Y N Heart Murmur/Mital Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: Hip-Knee _____ Other _____
16. Y N I smoke or use chewing tobacco. If yes, how much per day? How many years?
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery. Year ____ Type of operation _____ Year ____ Type of operation _____
21. Y N Do you have any other medical problem or medial history NOT listed on this form?
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type ____
25. Y N Diabetes
26. Y N Excessive Urination
27. Y N Infectious Mononucleosis
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted Diseases
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation/Therapy
35.
36. Y N AIDS
37. Y N Immune Suppressed **Disorder**
38. Y N Hearing loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders
42. Y N Are you taking birth control?
43. Y N Are you could you be pregnant or nursing?

Are you allergic to any of the following?
Please circle Y for yes or N for no.

44. Y N Aspirin?Ibuprofen
45. Y N Sulfa Drugs/Sulfites/Sulfides
46. Y N Penicillin
47. Y N Codeine
48. Y N Latex, Metals, Plastics
49. Y N Local anesthetics (Novocaine)
50. Y N Other Medications Which ones? _____

_____

Please list all medications you are currently taking:

_____

_____

_____

Physician's Name _____ Phone _____

Address _____ Fax _____

In the event of an emergency, please contact

Name _____ Relationship _____ Phone _____

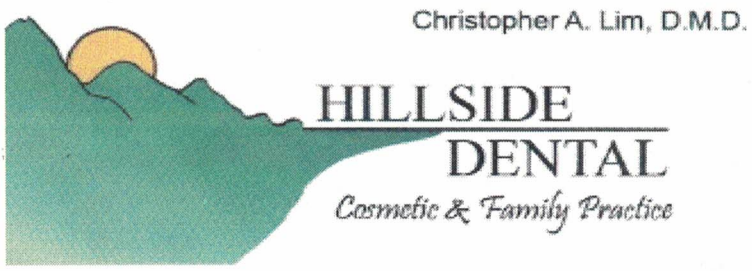
Name _____ Relationship _____ Phone _____

Medical health reviewed by:

X_____ ___/___/___
Doctor's Signature Date

X_____ ___/___/___
Patient's Signature Date

X_____ ___/___/___
If Patient is a minor, Parent/Guardian Signature Date



INSURANCE BILLING INFORMATION

As a courtesy to our patients, we can verify and file your insurance claims. We cannot however, guarantee payment. We suggest that you read your policy manual pertaining to your dental coverage. Many insurance companies have stipulations, such as usual and customary fees, deductibles, copayments, etc. This information will be listed in your policy manual. Please be aware of this and plan to make payments as services are rendered. In the event of denial from your insurance company any portion unpaid will be your responsibility.

Patient Initial_____

PAYMENT POLICY

I understand that I am finacially responsible for changes not paid by my insurance. I also understand that reasonable billing charges may be applied in order to collect any unpaid charges.

Patient Initial_____

CANCELLATION POLICY

I understand that ultimately I am responsible for keeping my appointments. If I am not able to make my appointment I must give at least 48 hours notice or I will be charged a minimum of $50.00 depending on appointment and treatment scheduled.

Patient Initial_____

_____ _____

Patient/Responsible Party **Date**