

**PATIENT INFORMATION**

Name: \_\_\_\_\_  Married  Single  Male  Female  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ SS # \_\_\_/\_\_\_/\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer/School: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Spouse's name: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_  
\* Whom may we thank for referring you to our office? \_\_\_\_\_

**ACCOUNT INFORMATION**

Person responsible for account: \_\_\_\_\_  
Address: (if different from above) \_\_\_\_\_ Phone: \_\_\_\_\_

**DENTAL INSURANCE** Please fill in all the information. We want to help you get the benefits available to you.

Person who subscribes to insurance: \_\_\_\_\_  Married  Single  Male  Female  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ SS # \_\_\_/\_\_\_/\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Group # \_\_\_\_\_ Insurance co. name: \_\_\_\_\_  
Insurance co. address: \_\_\_\_\_ Phone: \_\_\_\_\_

**I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.  
I authorize the dentist to release all information necessary to secure payment of benefits.**

**DENTAL INFORMATION**

Purpose for this dental appointment:  Check-up  Consultation  Pain  
Other dental concerns \_\_\_\_\_

**MEDICAL INFORMATION**

Are you under a physician's care now?  If so, why? \_\_\_\_\_  
Have you been hospitalized during the past two years?  If so why? \_\_\_\_\_  
What medications or drugs are you currently taking? \_\_\_\_\_  
Are you allergic to any medications or substance?  If so, which ones? \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ Women, are you pregnant? \_\_\_\_\_

Please circle any of the following you have had:

- |                          |                        |                      |                    |
|--------------------------|------------------------|----------------------|--------------------|
| Heart trouble            | Diabetes               | Hepatitis            | HIV/AIDS           |
| High blood pressure      | Artificial joints/hips | Asthma               | Venereal disease   |
| Low blood pressure       | Kidney trouble         | Cancer               | Herpes             |
| Heart murmur             | Scarlet fever          | Thyroid disease      | Bruise easily      |
| Rheumatic fever          | Sinus trouble          | Arthritis/gout       | Sickle cell anemia |
| Congenital heart lesions | Emphysema              | Cortisone medicine   | Psychiatric care   |
| Artificial heart valve   | Frequent cough         | Glaucoma             | Hypoglycemia       |
| Anemia                   | Lung disease           | Epilepsy or seizures | Allergies          |
| Fainting or dizziness    | Tuberculosis           | Drug addiction       | Ulcers             |
| Stroke                   | Liver disease          | Hemophilia           |                    |

Have you had any other serious illness?  If so what? \_\_\_\_\_

**MEDICAL UPDATES:**

Date: \_\_\_\_\_ Change: \_\_\_\_\_ By: \_\_\_\_\_ Date: \_\_\_\_\_ Change: \_\_\_\_\_ By: \_\_\_\_\_

**I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due at the time of treatment unless prior arrangements have been made. All accounts must be paid within 30 days. In the event that your account becomes delinquent, finance charges will accrue and the patient is responsible for all collection fees. A fee of \$50.00 will be charged for failed appointments without 24 hours notice.**

**SIGNATURE** (patient/parent): \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_