Name ______________________________ Date of Birth ______________

Address ______________________________ SSN ______________

City ______________________________ State __________ Zip ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ______________________________ Best Time to Contact You ______________

May We Email or Text You?

PERSON RESPONSIBLE FOR INSURANCE

Name ______________________________ Relationship ______________

Address ______________________________

Social Security Number ______________ Date of Birth ______________

Employer ______________ Home Phone ______________ Cell Phone ______________

PERSON RESPONSIBLE FOR PATIENT'S FINANCES

Name ______________ DOB ______________ Relationship ______________

Address ______________________________ SSN ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

THIS SECTION FOR OFFICE USE ONLY

Insurance Company ______________________________ Date Verified ______________

Ins. Contact ______________ Phone __________ Fax __________ Computer __________

Policy Number ______________ Group Number ______________ Effective Date __________

Missing Tooth Yes __________ No __________

Waiting Period Yes __________ No __________ Period Ends ______________

Deductible: __________ Yes __________ No $ ______________ Amount

If Yes: __________ Individual __________ Family __________ Annual __________ Lifetime

Frequencies on Exam ______________ PR ______________ Perio Maint ______________

Preventative ______________ Bitewings ______________ FMX/Pano ______________

Basic ______________________________

Major ______________________________

Yearly Maximum ______________ Replacement ______________

Sealants ______________ Fluoride ______________

Implant ______________ Nightguard ______________ Ortho ______________

Secondary Ins. Company Name ______________________________ Verified ______________

Name ______________ DOB ______________ SS# ______________

Employer ______________________________ Relationship ______________

Benefits ______________________________

PATIENT MEDICAL HISTORY

Are you under a physician's care now? ◯ Yes ◯ No ◯ N/A If yes, please explain: ____________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No ◯ N/A If yes, please explain: ____________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No ◯ N/A If yes, please explain: ____________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No ◯ N/A If yes, please explain: ____________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ◯ N/A ____________________

Are you on a special diet? ◯ Yes ◯ No ◯ N/A ____________________

Do you use tobacco? ◯ Yes ◯ No ◯ N/A

Do you use controlled substances? ◯ Yes ◯ No ◯ N/A

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?
- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Other If yes, please explain: ____________________

Do you have or have you had, any of the folllowing?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ◯ N/A ____________________

Are you happy with your smile? ◯ Yes ◯ No

If no, what would you change? ____________________

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

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________ DATE __________

FINANCIAL POLICY

Your insurance company is a contract between you, the insured, and the insurance company. The dental provider is not part of that contract. As a courtesy and service to you, we will file claims for you. Estimated co-payments and deductibles will be collected at the time of service. If your insurance company does not pay the claim in full, you will be responsible for payment of the remaining balance. By signing below, I understand and agree that I am ultimately responsible for my insurance co-payment, deductible, and any other procedures or fees not paid for or covered by my insurance company.

All balances will be due sixty days from the day of service, despite the actions of your insurance company. Monthly statements will be sent keeping you informed of the status of your account. We reserve the right to refer your account to a collection agency for any balance that remains ninety days from the date of service. We reserve the right to add additional collection fees up to 40% of the balance submitted to the collection agency and reasonable attorney fees.

Signature of Parent, Patient or Guardian ____________________ Date __________