

PLEASE COMPLETE ALL ITEMS ON THIS FORM AND RETURN TO RECEPTIONIST

Patient Name _____ Date of Birth _____
If Patient is child, Parent's Name _____
Street Address _____ Male or Female _____
City _____ State _____ Zip _____ Cell Phone (____) _____
Home Telephone (____) _____ Work Phone (____) _____
Name of Employer _____ Email Address _____
SS # of Patient _____ Driver's License # _____

Dental Insurance Yes No:

Policy Holder's Name _____ **Employer** _____

Ins Company _____ **Phone #** _____ **Group #** _____

Insured: SS# _____ **Date of Birth** _____

Whom may we contact in case of an emergency? _____
Phone# _____ Relationship _____

How did you hear about our office? _____

Do you or have you ever had any of the following:

Diabetes..... Yes No

Heart Condition Yes No

Explain _____

Abnormal Blood Pressure () High or () Low Yes No

Abnormal Bleeding from a Cut Yes No

Rheumatic Fever..... Yes No

Hepatitis..... Yes No

Joint Replacement. Yes No

Allergic to Any Medications Yes No

If yes: _____

Are you taking any medications? Yes or NO If yes, Please list _____

Are you under the care of a physician now? Yes or NO

If Yes, Name of Physician _____

Please explain reason: _____

PLEASE READ CAREFULLY:

I authorize the doctor to perform any and all forms of treatment that may be indicated in connection with the dental care of the patient above and to choose and employ such assistance as he sees it fit. I understand that prior to treatment; full explanation of the procedurs(s) involved will be given by the doctor and/ or his staff. I agree to pay for all services rendered at the time of treatment unless prior arrangements have been made. I understand the total balance for all services is my responsibility, including any remaining after insurance co-payment (1.5% per month finance charge will be applied to any remaining balance after 60 days from service date as well as a \$5.00 billing fee.)

Signed _____ Date _____

Relationship to Patient _____
