Welcome To Our Practice

Date _____

Patient Information

Name_____ Birth Date_____ Soc. Sec _____

Address _____ City_____ State _____ Zip _____

Email_____ Cell Phone _____ Home Phone _____

Work Phone_____

Check Appropriate Box □ Minor □ Single □ Married □ Divorced □ Domestic Partner

Patient's or Parent's Employer _____ Address_____

Employer City _____ State _____ Zip _____

Name of Person Responsible for this Account _____ Drivers License No. _____

Responsible Party's Address (if different from above) _____

Emergency Contact _____ Phone # _____ Relationship _____

Whom May We Thank For Referring You? _____

Insurance Information

Name of Insured _____ Birth Date_____ Soc. Sec. # _____

Relation To Patient _____ Address _____

City _____ State _____ Zip _____

Employer _____ Address _____ Date Employed _____

Insurance Group # _____Do You Have Dual Insurance? If Yes, Please Provide Copy Of Insurance Card.

Dental/Medical History

Reason for today's visit_____ Date of last dental visit _____ Date of last X-rays _____

Check if you have had any of the following:

□ Bad breath
□ Bleeding gums
□ Clicking or popping jaw
□ Food collection between the teeth
□ Grinding teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to heat
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores or growths in your mouth

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin, Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Have you had any serious illnesses or operations? □ Yes □ No If yes, please describe _____

Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate dates_____

Are you allergic to Latex or Metal? □ Yes □ No Please list any other allergies _____

Are you allergic to any medications? Please list _____

(Women) Are you Pregnant? □ Yes □ No Nursing? □ Yes □ No Taking Birth Control Pills? □ Yes □ No

Do you require antibiotics before a dental visit? If yes, please list: _____

List medications you are currently taking and the correlating diagnosis: _____

_____

Are you or have you taken any of the following medications (bisphosphonates) for Osteoporosis?

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
□	□	Didronel	□	□	Actonel	□	□	Boniva	□	□	Zometa	□	□	Prolia
□	□	Fosamax	□	□	Aredia	□	□	Bonefos	□	□	Skelid			

If you answered yes to any of the above, how long have you taken the medication? _____

Please check if you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
□	□	Anemia	□	□	Cortisone Treatments	□	□	Hepatitis	□	□	Scarlet Fever
□	□	Arthritis, Rheumatism	□	□	Cough, Persistent	□	□	High Blood Pressure	□	□	Shortness of Breath
□	□	Artificial Heart Valves	□	□	Cough up Blood	□	□	HIV/AIDS	□	□	Skin Rash
□	□	Artificial Joints	□	□	Diabetes	□	□	Jaw Pain	□	□	Stroke
□	□	Asthma	□	□	Epilepsy	□	□	Kidney Disease	□	□	Swelling of Feet or Ankles
□	□	Back Problems	□	□	Fainting	□	□	Liver Disease	□	□	Thyroid Problems
□	□	Blood Disease	□	□	Glaucoma	□	□	Mitral Valve Prolapse	□	□	Tobacco habit
□	□	Cancer	□	□	Headaches	□	□	Pacemaker	□	□	Tonsillitis
□	□	Chemical Dependency	□	□	Heart Murmur	□	□	Radiation Treatment	□	□	Tuberculosis
□	□	Chemotherapy	□	□	Heart Problems	□	□	Respiratory Disease	□	□	Ulcer
□	□	Circulatory Problems	□	□	Hemophilia	□	□	Rheumatic Fever	□	□	Venereal Disease

Authorization and Release

Our office is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. It must be clearly understood that the insurance "contract" is between you, the patient, and the insurance company. Therefore, you are responsible for any amount not paid by the insurance company. Although we are willing to complete insurance information forms and submit a claim on behalf of the patient, we do not accept responsibility—under any circumstance—for the outcome of the transaction. Completing insurance forms is a courtesy we extend to our patients in an effort to maximize their likelihood of obtaining insurance reimbursement. By having our office process insurance forms, the patient agrees to accept liability for those forms. Alternatively, a patient may fill out his/her own insurance forms and bill the insurance directly. The patient will pay the ***estimated*** co-payment (the amount not covered by the insurance company) at the time services are rendered. ***This is an estimate only***, and this amount may change based upon final insurance company payments. Our office does NOT guarantee that the patient's insurance company will pay for any procedure. You are responsible for any amount not paid by the insurance company. For any treatment, including dentures, partials, crowns/bridges, full co-payment will be due at the first visit. **For patients without insurance, full payment is due the day of treatment (including treatment for dentures, partials, crowns/bridges).**

I have read and answered the above questions to the best of my knowledge and agree to all of the above office policies. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient/responsible party Date