

WELCOME! This information allows us to start your permanent record:

Last Name _____ First Name _____ M.I. _____

Date of Birth _____ Sex _____ Occupation _____

Social Security Number _____ - _____ - _____

Name and Social Security Number of person responsible for this account if different from above:

_____ SS# _____ Birthdate _____

Mailing Address _____

Home Address _____

City _____ Zip _____ Phone(home) _____

Phone(work) _____ Fax _____ email _____

Contact in Emergency (not your home) _____

Relationship _____ Phone _____

How did you hear about our office? _____

In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with an estimate of the fee prior to treatment. To avoid the unnecessary extra work of mailing you a statement, **PAYMENT IN FULL IS REQUESTED AT THE TIME OF TREATMENT.** In addition to cash and local checks, we accept Visa, MasterCard, Discover, and American Express.

Signature _____ Date _____

For Patients with dental insurance:

PAYMENT IN FULL IS REQUESTED AT THE TIME OF TREATMENT. As a courtesy, we will be happy to submit your claim for reimbursement when you complete the information below.

Primary Insurance

Name of Insured _____ SS # _____ Birthdate _____
Employer Name _____
Employer Address _____
City _____ Zip _____ Wk Phone _____
Patient's relationship to the insured _____
Plan Name _____
Insurance Company Name _____ Group # _____
Insurance Co Address _____
City _____ State _____ Zip _____ Ins Phone _____

Secondary Insurance

Name of Insured _____ SS# _____ Birthdate _____
Employer Name _____
Employer Address _____
City _____ Zip _____ Wk Phone _____
Patient's relationship to the insured _____
Plan Name _____
Insurance Company Name _____ Group # _____
Insurance Address _____
City _____ State _____ Zip _____ Ins Phone _____

"I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to the insurance company or billing agency. This release is for the purpose of facilitating billing and reimbursement of professional fees to which I am entitled."

Date: _____ Signature _____

Your Name _____

Name of MD or Nurse Practitioner _____

This Medical Information is necessary for your care & safety. Your answers are Confidential.

Women - Is it possible you are pregnant? Yes No

Are you sensitive or allergic to: Penicillin Yes No

Aspirin Yes No

Codeine Yes No

Latex Yes No

Other _____

Please list drugs/prescriptions taken during the last two weeks:

Do you have or have you been treated for:

Heart Disease Yes No

Low/High Blood Pressure Yes No

Heart Murmur Yes No

Prolapsed Heart Valve Yes No

Diabetes Yes No

Migraine Headache Yes No

Tuberculosis Yes No

Rheumatic Fever Yes No

Hepatitis Yes No

Herpes Yes No

HIV Yes No

Arthritis Yes No

Seizure Disorder Yes No

Bleeding Disorder Yes No

Asthma Yes No

Pacemaker Yes No

Cancer Yes No

Hip or other Joint Replacement Yes No

Radiation Therapy Yes No

Blood Transfusion Yes No

Please list Major Operations _____

May we send postcards to remind you of appointments? Yes No

Date _____ Signed _____

(Patient or Guardian)

Updates as Noted

Date _____ Signed _____

Date _____ Signed _____