PATIENT INFORMATION

Chart No. ________

Name____ Title: Mr., Mrs., Dr., Ms. Home # ( ) ______________
Last First Middle

Work # ( )____________Cell # ( )_____________Home Address____
Street City State Zip

Sex: M or F SS #____________________Birthdate_____________________Age_______ Spouse/Parent ____________________________

E-Mail Address____Drivers License #____

Name & Town of School:____ Emergency Contact: _____________________________

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Employed by___________________________Work Address____
Street City State Zip

Dental Insurance__________________________Ins. Address____
Street City State Zip

ID #_________________________Ins. Phone # ( )_________________WHO REFERRED YOU TO US?_______________________

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Secondary Dental Insurance

Insured Name____ Birthdate ____________________

SS#____Ins. Co. ____

Ins. Address____

Group ID # _______________________________________Ins. Phone # ( )____

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CONFIDENTIAL MEDICAL HISTORY. Please circle those conditions that pertain to you:

Rheumatic Fever	High Blood Pressure	Stroke	Drug Addiction	Allergy to Metal	Hemophilia
Heart Murmur	X-ray/Cobalt Treatment	Ulcers	Psychiatric Treatment	Abnormal Bleeding	Scarlet Fever
Heart Disease	Hepatitis A-Infection	Cancer	Venereal Disease	Allergy/Hives	Fever Blister
Heart Transplant	Hepatitis B-Serum	Diabetes	Sickle Cell Anemia	Asthma/Hay fever	Bruises Easily
Heart Pacemaker	Hepatitis, Others	Arthritis	Thyroid Disease	Sinus Trouble	Alcoholism
Heart Surgery	Endocrine Problems	Liver Disease	Blood Transfusion	Cortisone Medicine	Tuberculosis
Artificial Implants	Faint/Dizzy Spells	HIV/AIDS	Epilepsy/Seizure	Yellow Jaundice	Rheumatism
				Chemotherapy	Pregnant

Others not listed ______________________________________Blood Relatives with above Conditions ______________________________

If recently hospitalized, Reason_______________________________ Medications currently taking __________________________________

Allergic to: Local Anesthetic, Latex, Darvon, Nitrous Oxide, Percodan, Codeine, Valium, Erythromycin, Penicillin, Others _____________________

_____________ Physician's Name ______________________________ City/State ______________________ Phone # ( ) _______________

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DENTAL HISTORY

	Yes	No		Yes	No		Yes	No
Do your gums bleed easily?	☐	☐	Do you grind or clench your teeth?	☐	☐	Injury to your mouth/face?	☐	☐
Do any of your teeth hurt?	☐	☐	Does your jaw pop or click?	☐	☐	Does food get between any teeth?	☐	☐
Wear dentures/partials?	☐	☐	Do you get frequent headaches?	☐	☐	Unhappy with your teeth?	☐	☐

Date of last dental visit and reason for last visit ____ Date of last X-ray of entire mouth _______

Former Dentist Name ____________________________ Address ______________________________________ Phone # ( ) ____________

Reason for leaving former dentist __________________________________ How can we help you? ____

If Patient is a minor...
Responsible person Name: _________________ _______ DOB: _______________________Address: __________________________________
For information, coomunication, and payment

Signature: ______________________________ Date: ______________________

Relation to patient : ______________________________________

SIGNATURE ON FILE / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

1 I authorize release of information to all my insurance carriers.
2 I authorize direct payment to my doctor
3 I allow a copy of this authorization to be used in place of the original.
4 I have received a copy of this office's Notice of PRIVACY PRACTICE.

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Patient Signature Date

OFFICE POLICY

1. Missed appointments without 24 hour advanced notice will be charged $25 per 30 minutes.
2. Payment (including co-pays and deductibles) is required when service is rendered. An insurance policy is an agreement between you and your insurance company. We will aid you in filling your dental claim. Ultimately you will be responsible for any payments due to us.
3. Unpaid accounts will be charged a 1.5% interest every 30 days and will be placed in collections after 90 days with an added administrative fee.
4. A $28 Bad Check Fee will be charged for all returned checks.
5. I authorize this office to communicate with me by Text _____ Email _____

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Print Signature Date