

PERSONAL AND HEALTH DATA (confidential)

If patient is under 18, please give information requested on parents/guardians

Patient Name		Age	Street Address & Mailing Address		City	State
					Zip	
Home Phone	Work Phone	Cell Phone	Email	Birthdate	S.S.#	
Employer & Address			Dental Ins. Carrier's Name		Policy Holder's Name & S.S. #	
Spouse's Name		Spouse's Employer & City		Do you have a 2 nd insurance carrier? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If YES to a second insurance carrier, give name of company:						

PLEASE LIST ANY MEDICATIONS YOU TAKE PERIODICALLY OR REGULARLY

Name Medication	Date First Taken	Name Medication	Date First Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO If yes, please list below

ARE YOU ALLERGIC TO ANY FOODS? OTHER SUBSTANCES? YES <input type="checkbox"/> NO <input type="checkbox"/> Please list below	

PLEASE X ANY OF THE FOLLOWING CONDITIONS THAT CURRENTLY OR IN PAST APPLY TO YOU.

EYES	NOSE	EARS	HEART	Mitral Valve Prolapse.....
Glaucoma..... <input type="checkbox"/>	Sinus..... <input type="checkbox"/>	Hearing Loss.. <input type="checkbox"/>	Rheumatic Fever... <input type="checkbox"/>	Surgery..... <input type="checkbox"/>
Loss of Vision... <input type="checkbox"/>	Nosebleeds..... <input type="checkbox"/>	Ringing..... <input type="checkbox"/>	Murmur..... <input type="checkbox"/>	Pacemaker..... <input type="checkbox"/>
Contact Lenses... <input type="checkbox"/>	Hay fever/Hives..... <input type="checkbox"/>	Surgery..... <input type="checkbox"/>	Attack..... <input type="checkbox"/>	High Cholesterol..... <input type="checkbox"/>
	Excessive Discharge... <input type="checkbox"/>		Angina..... <input type="checkbox"/>	Abnormal Blood Pressure..... <input type="checkbox"/>
RESPIRATORY			CANCER.....<input type="checkbox"/>	Type of Treatment:
Asthma..... <input type="checkbox"/>	Cystic Fibrosis..... <input type="checkbox"/>		Type..... <input type="checkbox"/>	Chemo..... <input type="checkbox"/>
Lingering cough..... <input type="checkbox"/>	Smoking..... <input type="checkbox"/>		Where..... <input type="checkbox"/>	Radiation.... <input type="checkbox"/>
Irregular Breathing... <input type="checkbox"/>	Packs per day _____		When Diagnosed:	Surgery..... <input type="checkbox"/>
Cough up Blood..... <input type="checkbox"/>	How many years _____		Present Status _____	Other..... <input type="checkbox"/>

MOUTH	TEETH	BONES	BLOOD
Gumboils..... <input type="checkbox"/>	Loose..... <input type="checkbox"/>	Arthritis..... <input type="checkbox"/>	Hemophilia..... <input type="checkbox"/>
Braces..... <input type="checkbox"/>	Sensitive Hot..... <input type="checkbox"/>	Gout..... <input type="checkbox"/>	Sickle Cell Anemia <input type="checkbox"/>
Broken Jaw..... <input type="checkbox"/>	Sensitive Cold..... <input type="checkbox"/>	Artificial Joints... <input type="checkbox"/>	AIDS-ARC..... <input type="checkbox"/>
Clicking Jaw..... <input type="checkbox"/>	Sensitive Sweets... <input type="checkbox"/>	Which? _____	
	Wedging Food..... <input type="checkbox"/>		
	Grinding..... <input type="checkbox"/>		

THROAT	STOMACH,ETC.	Acid Reflux...<input type="checkbox"/>	Loss Appetite.....<input type="checkbox"/>
Sore..... <input type="checkbox"/>	Hepatitis, Type..... <input type="checkbox"/>	Stool Blood.... <input type="checkbox"/>	Other..... <input type="checkbox"/>
Surgery..... <input type="checkbox"/>	Hernia..... <input type="checkbox"/>	Ulcers..... <input type="checkbox"/>	
Strep..... <input type="checkbox"/>	Stomach Pains..... <input type="checkbox"/>	Constipation.. <input type="checkbox"/>	
When?..... <input type="checkbox"/>	Vomiting..... <input type="checkbox"/>		
Difficulty Swallowing... <input type="checkbox"/>			
Hoarseness..... <input type="checkbox"/>			
Laryngitis..... <input type="checkbox"/>			
Lumps..... <input type="checkbox"/>			
Other..... <input type="checkbox"/>			

NERVOUS SYSTEM	ENDOCRINE/URINARY
Seizure..... <input type="checkbox"/>	Sugar Diabetes..... <input type="checkbox"/>
Stroke..... <input type="checkbox"/>	Bladder infect..... <input type="checkbox"/>
Tingling..... <input type="checkbox"/>	High Weight Loss..... <input type="checkbox"/>
Headaches... <input type="checkbox"/>	Frequent Urination... <input type="checkbox"/>
Panic..... <input type="checkbox"/>	Painful Urination.. <input type="checkbox"/>
Dizzy Spells..... <input type="checkbox"/>	
Numbness..... <input type="checkbox"/>	
Alcoholism..... <input type="checkbox"/>	
Memory Coord... <input type="checkbox"/>	
Emotional..... <input type="checkbox"/>	
Tiredness..... <input type="checkbox"/>	
Crying Spells..... <input type="checkbox"/>	

OB/GYN (Women Only) ARE YOU PREGNANT? YES NO

PREVIOUS DENTIST _____ LOCATION (CITY) _____

PHYSICIAN'S NAME _____ LOCATION (CITY) _____

Whom may we thank for referring you to us? _____ Phone _____

Whom may we contact in case of emergency? _____ Phone _____

Who is financially responsible for this bill? _____

1. How do you prefer to be addressed? _____

2. Approximate date of last Dental Exam _____ Last Dental Xrays _____

3. Purpose of this dental visit (Circle one): ROUTINE CARE EMERGENCY OTHER

CIRCLE

YES NO 4. Are you having pain or discomfort at this time? _____ Explain _____

YES NO 5. Do you feel very nervous about having dental treatment? _____

YES NO 6. Have you ever had a bad experience in the dental office? _____

YES NO 7. Is there anything that you dislike about your smile? If so, what? _____

YES NO 8. Have you ever had any instructions in oral hygiene? _____

YES NO 9. Do you have any trouble chewing? _____

YES NO 10. Does food catch between your teeth? _____ Which ones? _____

YES NO 11. Do you habitually clench or grind your teeth during the day or night? _____

YES NO 12. Have you ever been told that you have gum problems? _____

YES NO 13. Is there anything related to your medical or dental history that you have not indicated? _____ If yes, explain: _____

PAYMENT POLICY

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Mastercard, or Visa. We will be happy to help you process your insurance claim form which requires a completed insurance form. We accept assignment of insurance benefits with insurance companies participating in assignment.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If it becomes necessary for us to employ a collection agency, there will be a collection fee of 35% of the existing debt added to your amount due for accounts up to 9 months overdue to cover those expenses. For over 9 months, the collection fee will increase to 50% of the original debt.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and hereby agree to these terms.

Signature (Parent/Guardian if patient under 18) DATE _____

THERE WILL BE A CHARGE MADE FOR BROKEN APPOINTMENTS AND APPOINTMENTS CANCELLED WITHOUT 48 HOURS ADVANCE NOTICE.