

MAY WE GET TO KNOW YOU BETTER? Today's date _____				
Patient Name	Date of Birth	Do you have any general health problems? If so, please specify	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Social Security Number		Please list any drugs or medications you are currently taking:		
Residence address		To the best of your knowledge, are you or have you ever been diagnosed with:		
Phone Work:	Home:	Aids/HIV		
Cell Phone		Yes <input type="checkbox"/>		
Email		Heart Ailment, Mitral Valve Prolapse, Pacemaker		
Occupation		Yes <input type="checkbox"/>		
Spouse's Name		No <input type="checkbox"/>		
Whom may we thank for referring you?		Epilepsy		
Reason for today's visit		Yes <input type="checkbox"/>		
Person financially responsible for this account?		No <input type="checkbox"/>		
Person to contact in case of Emergency		Hepatitis		
I authorize Dr. Angeletti and RDH to perform the above procedures and I understand that payment is due at time that services are rendered. Also, I understand that insurance is an estimate and not a guarantee of benefits and any portion not covered by my insurance plan is my responsibility. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. In the case that it is necessary to send this to a collection agency or attorney I will incur the fees and those fees will be included on the invoicing. Date: _____ <input type="checkbox"/> Patient <input type="checkbox"/> Parent or <input type="checkbox"/> Legal Guardian		High Blood Pressure		
Signature: _____		Yes <input type="checkbox"/>		
I hereby authorize payment of the dental benefits otherwise payable to me directly to the dentist.		No <input type="checkbox"/>		
Signature: _____		Allergy to any Drugs/Latex If so, what?		
DENTAL INSURANCE INFORMATION		Fosamax or Bisphosphonates		
Insured's Name:		Yes <input type="checkbox"/>		
Insurance Company		No <input type="checkbox"/>		
		Joint Replacement?		
		Yes <input type="checkbox"/>		
		No <input type="checkbox"/>		
		If so, When?		
		Is there anything not listed here that may affect the health and/or safety of yourself or our staff that you can share now or would you prefer to share with the Doctor only?		
		Signature of Dentist: _____		
		Insurance company Phone number		
		Insurance ID number		