PATIENT INFORMATION

Name_____SSN_____Marital Status

Date of Birth_____Male / Female Married Single Child

Address_____

City_____State_____Zip_____

Home Phone _____ Work Phone_____Ext_____

Employer _____

Person Responsible for Payment_____Relationship_____

Referred By _____

MEDICAL HISTORY

	Yes	No
1. Are you presently receiving any medical treatment ?_____	[ ]	[ ]
2. Have you had any major operations ?_____	[ ]	[ ]
3. Do you have any allergies ?_____	[ ]	[ ]
4. Are you presently taking any medications ?_____	[ ]	[ ]
5. Have you ever had hepatitis or jaundice ?_____	[ ]	[ ]
6. Have you ever had a blood transfusion ?_____	[ ]	[ ]
7. Are you pregnant ? _____	[ ]	[ ]

8. Check any conditions that apply to you:

[ ] Heart Trouble	[ ] AIDS or HIV pos.	[ ] Hives or Rash
[ ] Heart Murmur	[ ] Thyroid Disease	[ ] Asthma /Hayfever
[ ] High Blood Press.	[ ] Kidney Disease	[ ] Diabetes
[ ] Rheumatic Fever	[ ] Liver Disease	[ ] Arthritis
[ ] Epilepsy	[ ] Ulcers/Stomach	[ ] Anemia
[ ] Venereal Disease	[ ] Sinus Problems	[ ] Tuberculosis
[ ] Stroke	[ ] Cancer	

9. Have you ever had excessive bleeding ?_____	[ ]	[ ]
10. Do you at present have any dental complaints ?_____	[ ]	[ ]

11. When was your last full mouth x-ray taken ?_____

12. Explain any unusual medical or dental problems.

Signature _____Date _____

INSURANCE INFORMATION

Person Responsible for payment

Name _____ SSN _____ Marital Status

Date of Birth _____ Male/Female Married Single Child

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____

Employer Name _____

Employer Address _____

PRIMARY INSURANCE

Subscribers Name _____

Insurance Company _____

Group Plan _____

Group Number _____ Subscriber ID Number _____

Insurance Co. Address _____

City _____ State _____ Zip _____

SECONDARY INSURANCE

Subscribers Name _____

Insurance Company _____

Group Plan _____

Group Number _____ Subscriber ID Number _____

Insurance Co. Address _____

City _____ State _____ Zip _____

I Authorize release of any information relating to this claim. Iunderstand that I am responsible for all costs of dental treatment.
Signature _____ Date _____
(signature required for us to submit your insurance claim by computer.)

I hereby authorize payment directly to the below named dentist of the dental benefits otherwise payable to me.
Signature _____ Date _____
(signature required for us to accept assignment of benefits.)

OFFICE FINANCIAL POLICY: Payment is expected at the time of your appointment. As a courtesy to our patients we will accept assignment of benefits for the estimated insurance coverage. Your uncovered portion is due at the time of service and can be paid with cash, check, Visa , Mastercard, Discover, or American Express. When your insurance payment is received and covers less than the estimated amount, then we will bill you for the difference.