

PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARD

≈≈ABOUTYOU≈≈

	oday's Date:			SS#:		
Name:						
Last		First		Middle Name		
I prefer to be called:	Birt	thdate:/	/ Age:	□Male □Female		
Home Address:			200			
Email Address:			City	State Zip Code		
Home #: ()	Cell#:()		Work#:()			
□Single □Married	□Divorced	□Widowed	□Separated	□Partner		
Employer:		Address:				
Whom may we thank for referring y	ou?					
Previous/Present Dentist:		Phone#:	LastVis	Last Visit Date:		
			<u>V≈≈</u>			
PERSON RESPONSIBLE FOR AC Relationship: Employer:	Birthdate:		SS#:			
Relationship:	Birthdate:		SS#:			
Relationship: Employer:	Birthdate:	<u> </u>	SS#:			
Relationship: Employer: Billing Address:	Birthdate: Work#:())	SS#:			
Relationship: Employer: Billing Address: Home #: ()		// 	SS#:			
Relationship:	Birthdate: Work#:(Dental Coverage _\		SS#: 			
Relationship: Employer: Billing Address: Home #: () PRIMARY INSURANCE Insurance Co. Name:		/ / / //ES □NO Insured's	SS#: Phone: Employer:			
Relationship: Employer: Billing Address: Home #: () PRIMARY INSURANCE Insurance Co. Name: Insured'sName: Group # (Plan, Local, Policy):		/	SS#: Phone: Employer:			
Relationship: Employer: Billing Address: Home #: () PRIMARY INSURANCE Insurance Co. Name: Insured'sName: Group # (Plan, Local, Policy):		// /ES □NOInsured'sSS#/ES □NO	SS#: Phone: Employer: Insured's Birt	hday//		
Relationship: Employer: Billing Address: Home #: () PRIMARY INSURANCE Insurance Co. Name: Insured'sName: Group # (Plan, Local, Policy): SECONDARY INSUREANCE	Work#: (Dental Coverage \(\text{\text{N}} \) Relation: Dental Coverage \(\text{\text{\text{N}}} \)	/ / / //ES □NO //ES □NO //ES □NO	SS#: Phone: Employer: Insured's BirtiPhone:	hday//		

PAYMENTIS DUE IN FULL AT THE TIME OF TREATMENT

UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE DATE

CANCELLATION POLICY

≈≈ DENTAL HISTORY≈≈

Y N Dizziness Y N LowBloodPressure Y N Tuberculosis (TB)	WHYH	AVEYOU COME TO THE DENTIST	TTODAY?			
INCASE OF EMERGENCYWHO SHOULD WE CONTACT: Physician's Name:	Are you	currently in pain? □YES □NO	Do	you require antibiotics before dental w	vork? □Y	ES □NO
Physician's Name:			<u>≈≈ //</u>	IEDICAL HISTORY≈≈		
Physician's Name:	IN CASI	E OF EMERGENCY WHO SHOULD	WECONTAC	CT:		
Are you currently under the care of a physician? Why? Date of Last visit:						
Date of Last visit:						
Do you have a history of smoking or using tobacco products?						
Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? YES NO Have you had a heart valve replacement or total joint replacement?				•		. .
Have you had a heart valve replacement or total joint replacement? Please list any prescription, over-the-counter or herbal supplement drugs you are taking? HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS Y. N. Abnormal Bleeding/Hemophilia Y. N. Epilepsy Y. N. Mitral Valve Prolapse Y. N. Alcohol/Drug Abuse Y. N. Fainting Spells Y. N. Pacemaker Y. N. Arthritis Y. N. Glaucoma Y. N. Pachtritis Y. N. Hay Fever Y. N. Radiation Treatment Y. N. Arthritis Y. N. Hay Fever Y. N. Radiation Treatment Y. N. Arthritis Y. N. Hay Fever Y. N. Radiation Treatment Y. N. Ashtma Y. N. Heart Murmur Y. N. Scarlet Fever Y. N. Ashtma Y. N. Heart Murmur Y. N. Scarlet Fever Y. N. Blood Transfusion Y. N. Hepatitis Y. N. Seizures Y. N. Cancer/Chemotherapy Y. N. Hepatitis Y. N. Singles Y. N. Congenital Heart Defect Y. N. Hospitalized for any reason Y. N. Sinus Problems Y. N. Difficulty Breathing Y. N. Liver Disease Y. N. Difficulty Breathing Y. N. Liver Disease Y. N. Difficulty Breathing Y. N. Liver Disease Y. N. Tuberculosis (TB) Y. N. Emphysema Y. N. Lupus Y. N. Ulcers Y. N. Liver Disease Y. N. Trouble falling asleep Y. N. Frequent Headaches Y. N. Trouble falling asleep Y. N. Frequent Headaches Y. N. Trouble falling asleep Y. N. Frequent Headaches Y. N. Trouble falling asleep Y. N. Aspirin Y. N. Erythromycin Y. N. Penicillin Y. N. Codeine Y. N. Jewelry/Metal Y. N. Tetracycline Y. N. Dental Anesthetics Y. N. Latex Y. N. Other Please list any other drugs/materials that you are allergic to: FORWOMEN: Are you using birth control? YES N. Pregnant? YES N. D. Junderstand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.	•		•			
Please list any prescription, over-the-counter or herbal supplement drugs you are taking? HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS Y N Abnormal Bleeding/Hemophilia Y N Epilepsy Y N Mitral Valve Prolapse Y N Accohol/Drug Abuse Y N Fainting Spells Y N Pacemaker Y N Anemia Y N Glaucoma Y N Psychiatric Problems Y N Arthritis Y N Hay Fever Y N Radiation Treatment Y N Arthritis Y N Hay Fever Y N Redulation Treatment Y N Arthritis Y N Heart Murmur Y N Scarlet Fever Y N Asthma Y N Heart Murmur Y N Scarlet Fever Y N Hepatitis Y N Scarlet Fever Y N Hepatitis Y N Scarlet Fever Y N Hepatitis Y N Scarlet Fever Y N Cancer/Chemotherapy Y N Herpes/Fever Blisters Y N Shingles Y N Colitis Y N High Blood Pressure Y N Sickle Cell Dis/Traits Y N Collitis Y N High Blood Pressure Y N Sickle Cell Dis/Traits Y N Diabetes Y N Kidney Problems Y N Stroke Y N Difficulty Breathing Y N Liver Disease Y N Thyroid Problems Y N Diziness Y N Lupus Y N Lupus Y N Ulcers Y N Frequent Headaches Y N Trouble falling asleep Y N Tuberculosis (TB) Y N Emphysema Y N Lupus Y N Ulcers Y N Frequent Headaches Y N Trouble falling asleep Y N Wake Rested Y N Ringing in ears Y N Trouble falling asleep Please list any serious medical conditions that you have ever had: AREYOU ALLERGIC TO ANY OF THE FOLLOWING? Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine Y N Jewelry/Metal Y N Tetracycline Y N Dental Anesthetics Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: FOR WOMEN: Are you using birth control? Set Sin No Pregnant? Set Sin No Understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.	-		•			
HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS Y N Abnormal Bleeding/Hemophilia Y N Epilepsy Y N Mitral Valve Prolapse Y N Alcohol/Drug Abuse Y N Fainting Spells Y N Pacemaker Y N Anemia Y N Glaucoma Y N Psychiatric Problems Y N Arthritis Y N Arthritis Y N Arthritis Y N Hay Fever Y N Radiation Treatment Y N Arthritis Bone/Joints/Valves Y N Heart Attack/Surgery Y N Reheumatic Fever Y N Asthma Y N Heart Attack/Surgery Y N Reheumatic Fever Y N Asthma Y N Heart Murmur Y N Scarlet Fever Y N Scarlet Fever Y N Cancer/Chemotherapy Y N Hepatitis Y N Seizures Y N Shingles Y N Colitis Y N Hepatitis Y N Seizures Y N Shingles Y N Colitis Y N Hospitalized for anyreason Y N Sicke Cell Dis/Traits Y N Congenital Heart Defect Y N Hospitalized for anyreason Y N Sinus Problems Y N Diabetes Y N Kidney Problems Y N Liver Disease Y N Kidney Problems Y N Stroke Y N Difficulty Breathing Y N Liver Disease Y N Thyroid Problems Y N Digranes Y N Lupus Y N Lupus Y N Ulcers Y N Frequent Headaches Y N Trouble falling asleep Y N Wake Rested Y N Frequent Headaches Y N Trouble staying asleep Please list any serious medical conditions that you have ever had: ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? Y N Aspirin Y N Erythromycin Y N Dental Anesthetics Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: FOR WOMEN: Are you using birth control? YES NO Pregnant? YES NO Due: Nursing? YES NO Anything you would like to discuss with the dentist in private? YES NO Junderstand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.	-					
Y N Abnormal Bleeding/Hemophilia Y N Epilepsy Y N Mitral Valve Prolapse Y N Alcohol/Drug Abuse Y N Fainting Spells Y N Pacemaker Psychiatric Problems Y N Anemia Y N Glaucoma Y N Psychiatric Problems Y N Arthritis Y N Hay Fever Y N Radiation Treatment Y N Arthritis Y N Hay Fever Y N Radiation Treatment Y N Arthritis Y N Heart Attack/Surgery Y N Rehumatic Fever Y N Asthma Y N Heart Murmur Y N Scarlet Fever Y N Asthma Y N Heart Murmur Y N Scarlet Fever Y N Hold Transfusion Y N Hepatitis Y N Seizures Y N Cancer/Chemotherapy Y N Herpes/Fever Blisters Y N Shingles Y N Collitis Y N High Blood Pressure Y N Schiec Cell Dis/Traits Y N Congenital Heart Defect Y N Hospitalized for any reason Y N Sinus Problems Y N Diabetes Y N Kidney Problems Y N Stroke Y N Difficulty Breathing Y N Liver Disease Y N Thyroid Problems Y N Dizziness Y N Low Blood Pressure Y N Tuberculosis (TB) Y N Emphysema Y N Lupus Y N Ulcers Y N Frequent Headaches Y N Trouble falling asleep Y N Frequent Headaches Y N Trouble staying asleep Please list any serious medical conditions that you have ever had: ARE Y OU ALLERGIC TO ANY OF THE FOLLOWING? Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine Y N Jewelry/Metal Y N Tetracycline Y N Dental Anesthetics Y N Latex Y N Other FOR WOMEN: Are you using birth control? YES NO Pregnant? YES NO Due: Nursing? YES NO Anything you would like to discuss with the dentist in private? YES NO Iunderstand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.	Please	list any prescription, over-the-counte	er or herbal sup	oplement drugs you are taking?		
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Y N Anemia Y N Glaucoma Y N Psychiatric Problems Y N Arthritis Y N HayFever Y N Radiation Treatment Y N Arthritis Y N HayFever Y N Radiation Treatment Y N Arthritis Y N Heart Murmur Y N Radiation Treatment Y N Asthma Y N Heart Murmur Y N Scarlet Fever Y N Asthma Y N Heart Murmur Y N Scarlet Fever Y N Blood Transfusion Y N Hepatitis Y N Scizures Y N Cancer/Chemotherapy Y N Hepatitis Y N Scizures Y N Concer/Chemotherapy Y N High Blood Pressure Y N Sickle Cell Dis./Traits Y N Congenital Heart Defect Y N High Blood Pressure Y N Sickle Cell Dis./Traits Y N Congenital Heart Defect Y N Hospitalized for any reason Y N Sinus Problems Y N Difficulty Breathing Y N Liver Disease Y N Kidney Problems Y N Stroke Y N Direction Y N Liver Disease Y N Thyroid Problems Y N Dizziness Y N LowBlood Pressure Y N Tuberculosis (TB) Y N Emphysema Y N Lupus Y N Ulcers Y N Frequent Headaches Y N Trouble falling asleep Y N Wake Rested Y N Ringing in ears Y N Trouble staying asleep Please list any serious medical conditions that you have ever had: ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? Y N Aspirin Y N Erythromycin Y N Penicillin Y N Tetracycline Y N Dental Anesthetics Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: FOR WOMEN: Are you using birth control?						
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Y N Asthma Y N Heart Murmur Y N Scarlet Fever Y N Blood Transfusion Y N Hepatitis Y N Seizures Y N Cancer/Chemotherapy Y N Herpes/Fever Blisters Y N Shingles Y N Colitis Y N High Blood Pressure Y N Sickle Cell Dis./Traits Y N Congenital Heart Defect Y N Hospitalized for any reason Y N Sinus Problems Y N Diabetes Y N Kidney Problems Y N Stroke Y N Difficulty Breathing Y N Liver Disease Y N Thyroid Problems Y N Dizziness Y N LowBlood Pressure Y N Thyroid Problems Y N Dizziness Y N LowBlood Pressure Y N Tuberculosis (TB) Y N Emphysema Y N Lupus Y N Ulcers Y N Frequent Headaches Y N Trouble falling asleep Y N Wake Rested Y N Ringing in ears Y N Trouble staying asleep Please list any serious medical conditions that you have ever had: ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine Y N Jewelry/Metal Y N Tetracycline Y N Dental Anesthetics Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: FOR WOMEN: Are you using birth control? YES NO Pregnant? YES NO Due: Nursing? YES NO Anything you would like to discuss with the dentist in private? YES NO I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.						
Y N Blood Transfusion Y N Hepatitis Y N Seizures Y N Cancer/Chemotherapy Y N Herpes/Fever Blisters Y N Shingles Y N Coltis Y N High Blood Pressure Y N Shingles Y N Congenital Heart Defect Y N Hospitalized for any reason Y N Sickle Cell Dis./Traits Y N Congenital Heart Defect Y N Hospitalized for any reason Y N Sickle Cell Dis./Traits Y N Diabetes Y N Kidney Problems Y N Stroke Y N Diabetes Y N Kidney Problems Y N Stroke Y N Diabetes Y N Liver Disease Y N Thyroid Problems Y N Dizziness Y N Low Blood Pressure Y N Thyroid Problems Y N Emphysema Y N Lupus Y N Ulcers Y N Frequent Headaches Y N Trouble falling asleep Y N Ringing in ears Y N Trouble staying asleep Please list any serious medical conditions that you have ever had: AREYOU ALLERGIC TO ANY OF THE FOLLOWING? Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine Y N Jewelry/Metal Y N Tetracycline Y N Dental Anesthetics Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: FOR WOMEN: Are you using birth control? YES NO Pregnant? YES NO Due: Nursing? YES NO Anything you would like to discuss with the dentist in private? YES NO I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.						
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Y N Difficulty Breathing Y N Liver Disease Y N Thyroid Problems Y N Dizziness Y N LowBlood Pressure Y N Tuberculosis (TB) Y N Emphysema Y N Lupus Y N Ulcers Y N Frequent Headaches Y N Trouble falling asleep Y N Wake Rested Y N Ringing in ears Y N Trouble staying asleep Please list any serious medical conditions that you have ever had: ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine Y N Jewelry/Metal Y N Tetracycline Y N Dental Anesthetics Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: FOR WOMEN: Are you using birth control? YES NO Pregnant? YES NO Due: Nursing? YES NO Anything you would like to discuss with the dentist in private? YES NO Iunderstand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.						
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