~ WELCOME TO OUR OFFICE ~

DATE______________________

Your time and feelings are most important to us; we therefore ask the following questions to help us best serve your needs. This information is confidential. Please print clearly. Thank you.

PATIENT'S NAME ______________________ AGE ________ BIRTH DATE ______________

MAILING ADDRESS ______________________ PH# ____________ CELL# ______________

CITY ______________________ STATE __________ ZIP ______________

PATIENT EMPLOYED BY ______________________ PH# ______________

NAME OF SPOUSE ______________________ SS# ______________

SPOUSE EMPLOYED BY ______________________ PH# ______________

IF A CHILD, PARENT'S NAME ______________________ SS# ______________

IF A CHILD, MOTHER EMPLOYED BY ______________________ PH# ______________

IF A CHILD, FATHER EMPLOYED BY ______________________ PH# ______________

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO

POLICY NUMBER ______________ INSURANCE COMPANY ______________ SS# ______________

BIRTH DATE ______________

CONTACT PERSON IN THE EVENT OF AN EMERGENCY? ______________ PH# __________ CELL# __________

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ______________________ SS# ______________

MAILING ADDRESS ______________________ PH# ______________

MISSION STATEMENT: Our office policy is to provide our patients with the best quality dental care in a comfortable, affordable and timely manner. We will stand by our dental treatment, provided you are as committed to your oral health as we are; by keeping all scheduled appointments, following our treatment recommendations and staying current on your preventive recare appointments. We will honor your appointment times and we request that you honor them as well.

All professional services are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.
Interest will charged on unpaid accounts after 30 days at the rate of 2% per month, with a minimum of $2.00. Any accounts extending 60 days will be assigned to our collection department. In the event this account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney fees.

The above information was given by ______________________________ Date ______________

Signature

If you have dental insurance, please read and sign the following release.

I have reviewed the following treatment plan and fees. 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 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.

______________________ ______________

Signed (Patient, or Parent if minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

______________________ ______________

Signed (Employee/Subscriber) Date

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MEDICAL HISTORY

CIRCLE

1. Have you been a patient in the hospital during the past two years? YES NO Why? ______________________________
2. Have you been under the care of a medical doctor during the past two years? .... YES NO
   Name and address of Physician ____
3. Have you taken any medicine or drugs during the past two years? (i.e., Oral Contraceptives) .... YES NO
   If yes: please list on back of this sheet ....
4. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, latex, metals, milk or dairy products, iodine, or any drugs or medications? .... YES NO
5. Circle any of the following which you have had, or have at present:

Heart Attack	Artificial Joint	Radiation Therapy	Osteoporosis/medication
Heart Murmur/Mitro Valve Prolapse	Chest Pains/nitro	Pain in Jaw Joints	Alcohol Addiction
Rheumatic Fever	Emphysema	Allergies/Hive/Rash	Venereal Disease
Heart Surgery	Asthma/inhaler	Kidney Diseases	Epilepsy/Seizures
Heart Pacemaker	Tuberculosis (TB)	AIDS/HIV Positive	Fainting/Dizzy Spells
Artificial Heart Valve/Valve Damage	Sinus Trouble	Hepatitis	Bruise Easily
Swelling Feet/Ankles	Diabetes	Liver Disease	Prolonged Bleeding
Stroke	Thyroid Disease	Jaundice	
High Blood Pressure	Cancer/Leukemia/Tumor	Blood Transfusion	

6. Have you recently substituted herbs for prescription or over the counter drugs? .... YES NO
   If yes: please list on back of this sheet ....
7. Do you have any disease, condition or problem not listed? .... YES NO
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are tired? .... YES NO
9. WOMEN: Are you pregnant now? .... YES NO

It is the policy of this office to premedicate for the following conditions: Rheumatic fever or heart murmur with valve damage, prosthetic heart valve replacement, and prosthetic joint replacement-if recommended by your M.D.

DENTAL HISTORY

1. Are you having any dental problems/discomfort?______________ Explain:____
2. When was your last exam?____________________ Were x-rays taken?____
3. Are any of your teeth sensitive to the following: hot / cold / sweets?
4. Do your gums bleed? _______ Do you grind or clench your teeth? _________ When?______________________________
5. Have you ever had or do you have blisters/sores on your lips/mouth? ____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform you at the next appointment without fail.

______________ Date

____________________________________ Staff Signature

____________________________________ Signature of Patient, Parent or Guardian

MEDICAL HISTORY/PHYSICIAN EVALUATION UPDATE

Date	Addition	Patient Signature	Date	Addition	Patient Signature

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