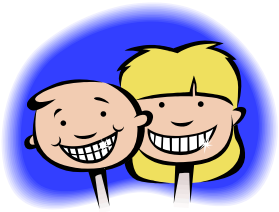

Thank You for Selecting Our Dental Team!

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name_____ Date _____

Soc. Sec._____ Birth date_____Email_____

Phone #_____Cell or Landline (Select) Other Phone #_____Cell or Landline (Select)

Address _____ City _____ State _____Zip_____

Check Appropriate Box: ❑ Minor ❑ Single ❑Married ❑Divorced ❑Widowed ❑Separated

If Student, Name of School/College _____ City _____ State___ ❑Full Time ❑Part Time

Name of Person Responsible for this Account (if different from above)_____ _____

Relationship to Patient _____

Address of Responsible Party _____

Home Phone _____Birth date_____

Employer_____Work Phone_____SSN# _____

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Please check the method of payment you prefer.

❑Payment in full at each appointment.
❑Cash ❑Personal Check ❑Debit Card Credit Card: ❑VISA ❑MasterCard ❑Discover
❑I wish to discuss the office's payment policy.
❑Twelve month no-interest financing with Care Credit Card.

Dental Insurance Information

Name of Insured _____ Relationship to Patient_____
Birth date_____ Social Security #_____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Employer Address_____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID #_____
Ins. Co. Address _____ City _____ State _____ Zip _____

Do You Have Any Additional Dental Insurance? ❑ Yes ❑ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient_____
Birth date _____ Social Security # _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Employer Address_____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID #_____
Ins. Co. Address _____ City _____ State _____ Zip _____

Continued on Back

Patient Medical History

Physician_____Office Phone_____Date of Last Exam _____

	Yes	No
1. Are you under medical treatment?	❑	❑
If yes, please explain _____		
_____		
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain _____		
_____		
_____		
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking?		
_____		
_____		
_____		

	Yes	No
4.Have you ever taken Phen-Fen / Redux?	❑	❑
5.Do you use tobacco?	❑	❑
6.Do you use controlled substances?	❑	❑

7. Are you **allergic** to or have you had any reactions to the following:

	Yes	No		Yes	No
Local Anesthetics (e.g. novocain)	❑	❑	Sulfa Drugs	❑	❑
Penicillin or other Antibiotics	❑	❑	Barbiturates	❑	❑
Latex Rubber	❑	❑	Sedatives	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑	Iodine	❑	❑
Other	❑	❑	Aspirin	❑	❑

8. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

9. Do you have or have you had any of the following, please mark all?

	Yes	No		Yes	No		Yes	No
Heart Attack/Heart Disease	❑	❑	Diabetes	❑	❑	Tuberculosis	❑	❑
Rheumatic Fever	❑	❑	Epilepsy/Convulsions	❑	❑	AIDS or HIV Infection	❑	❑
Cardiac Pacemaker	❑	❑	Stroke	❑	❑	Sexually Transmitted Disease	❑	❑
Heart Murmur	❑	❑	Fainting/Seizures	❑	❑	Radiation Therapy	❑	❑
Chest Pains	❑	❑	Stomach Troubles/Ulcers	❑	❑	Glaucoma	❑	❑
Mitral Valve Prolapse	❑	❑	Cancer	❑	❑	Arthritis	❑	❑
High Blood Pressure	❑	❑	Emphysema	❑	❑	Joint Replacement or Implant	❑	❑
Low Blood Pressure	❑	❑	Asthma	❑	❑	Other	❑	❑
Anemia/Bleeding Disorder	❑	❑	Hepatitis/Jaundice	❑	❑			

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last X-Rays _____

	Yes	No
1. Do you currently or have you recently had any teeth hurt?	❑	❑
2. Do you have any other oral health concerns?	❑	❑
_____		
_____		
3. Do you have jaw/muscle pain or headaches?	❑	❑
4. Are you interested in whitening?	❑	❑
3. Are you interested in orthodontics?	❑	❑

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature for Authorization, Release, and Notice of Privacy Practices Date