

Welcome To Our Practice

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		PATIE	NT INFORI	Mation			
Date	Name by v	vhich you pref	er to be called				
Patient's Name							
	Last		First		Middle		
Billing Address	Street		City		State	Zip	
Street Address	Outet				State	ZIр	
	Street		City		State	Zip	
Male 🗆 Female 🗇		Single 🗆 .	Married 🗇	Separated	Divorced 🗇	Other 🗇	
Birthdate	Age		Social S	ecurity #			
Home Phone	c	ell		E-Mail Addr	ess		
Work Phone							
Are you a full-time student?					. –		
Purpose of today's visit			Но	w long since your	last cleaning &	exam?	
Spouse's Name	Last		First		Middle		
Spouse's Employer			Sp	ouse's Work Phor	ne		
Spouse's Social Security Number							
Whom may we thank for refe							
Whom may we mank for rele	aning you to our o	ilice?	·				
What would you change abo	ut your smile?						
Would you like your teeth whiter?							
	DARENT	OPIEC	I CHADD	IAN INFORM	ATION		
Diagon							
	complete if full-	time student	or under 18 ye	ears old. (Person	responsible t	or bill)	
Name	Last	First		Middle		Marital Status	
Mailing Address						Thursday Orange	
Walling Address	Street		City		State	Zip	
Home Phone		Work Phone		Emplo	yer		
Social Security #							
DENTAL I	NSURANCE	INFORMA	TION - PLI	EASE PROVI	DE COPY	OF CARE	
Do you have dental insurance		No 🗇		ou have secondar		Yes 🗖	No 🗖
Policy Holder				licy Holder			
Date of Birth				ate of Birth ubscriber #		Group #	-
Subscriber # Insurance Company				surance Company			
Employer of insured				nployer of insured			
Relationship of insured to pat				elationship of insu			
	-				-		
				RMATION -			
Name & relationship of nearest relative not living with you							
Complete Address				·····			
Phone							

Please complete other side 🖙

HEALTH INFORMATION

Do you have or have you ever had any of the following?							
Yes No			. Yes No				
		Kidney Disease, Renal Failure or	☐ Abnormal Heart Condition				
		Kidney Transplant (circle one)	Mitral Valve Prolapse				
		Asthma `	Abnormal Blood Pressure				
		Allergies	Heart Murmur				
		Diabetes	Abnormal Bleeding				
		Sexually Transmitted Disease (STD)	Rheumatic Fever				
		HIV or AIDS	Joint Replacement				
		Tuberculosis					
	_	When?	Treatment?				
] 🖳		nepatitis	Treatment?				
		Radiation Treatment	reatment?				
_			Why?				
		Are you under a physician's care now? Wh	iv?				
		Are you taking any pills, drugs or medication	on, herbal or dietary supplements? If so, list:				
		Are you allowed to only drawn or least and	Al-al-and-day-				
Are you allergic to any drugs or local anesthetic or had unusual reaction? List:							
	☐ Are you allergic to any metals, jewelry or latex? (Circle)						
		Do you have headaches? Migraine, tensio	n or TMJ (Circle)				
_	Explain:						
		Is there any chance that you could be preg	nant? How many weeks?				
le th	e you	been hospitalized recently?	know? Explain:				
13 111	ci e ai	iy information about your fleatti we should r	diow? Explain:				
			And the state of t				
To A	All Pa	atients					
As a	cou	tesy to you, this office will file your dental	insurance; however, we are not a preferred provider or an				
in-n	etwor	k dentist. Different insurance policies pay	varying percentages for dental procedures and therefore it arges owed by the patient. If there is a refund or a balance				
IS NO	ot pos	isible to estimate the exact amount of cha	arges owed by the patient. If there is a refund or a balance of receipt of insurance payment. Any charges not paid by				
Insu	rance	within 60 days of filing are the responsib	pility of the nationt including any interest accumulated at a				
monthly periodic rate of 1.5%. I understand the insurance information above and agree to these terms. If I am							
uninsured, I realize that all charges for treatment are my sole responsibility at time of service.							
	ature:		Date:				
of Pe	ersons	Reponsible for Bill					
OFFICE USE ONLY							
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