Personal Information

PATIENT INFORMATION			
Last Name:	**First Name:**		**MI:**
Physical Address:	**City/State/Zip:**		
Mailing Address (if different)	**City/State/Zip**		
Home Phone:	**Work Phone:**	**Cell Phone:**	**Okay to Text? Y N**
Email Address:			
Date of Birth: / /	**Gender: M F**	**Marital Status: S M D W**	
SS#:	**Driver's License #:**	**Is patient a full-time student? Y N**	
Please let us know how you were referred to our practice – if an existing patient referred you, please provide their name:			

SPOUSE/RESPONSIBLE PARTY INFORMATION			
Last Name:	**First Name:**		**MI:**
Relationship to Patient: SELF SPOUSE PARENT STEP-PARENT OTHER:			
Physical Address:	**City/State/Zip:**		
Mailing Address (if different)	**City/State/Zip**		
Home Phone:	**Work Phone:**	**Cell Phone:**	
Email Address:			
Date of Birth: / /	**Gender: M F**	**Marital Status: S M D W**	
SS#:	**Driver's License #:**	**Employer:**	

DENTAL INSURANCE INFORMATION			
Policyholder Last Name:	**First Name:**		**MI:**
Relationship to Patient: SELF SPOUSE PARENT STEP-PARENT OTHER:			
Physical Address:	**City/State/Zip:**		
Mailing Address (if different)	**City/State/Zip**		
Home Phone:	**Work Phone:**	**Cell Phone:**	
Email Address:			
Date of Birth: / /	**Gender: M F**	**SS#:**	
Employer/Plan Name:	**Group #:**	**Member ID#:**	
Insurance Co. Name:	**Insurance Co. Phone:**		
Insurance Co. Address:	**City/State/Zip:**		
Are we authorized to release necessary information to your dental carrier for claims processing purposes? YES NO			
Do you authorize your dental carrier to issue payment directly to our office? YES NO			

FINANCIAL POLICY

All fees are the responsibility of the patient/responsible party and are payable at the time of service. Please be advised that we may obtain a credit report. We accept cash, checks and all major credit cards as well as Care Credit. For our patients with dental insurance, we will submit claims as a courtesy, based on the information that you have provided. We do not have access to individual plan information; this information should be obtained from your insurance company or the employer. We do not participate in contracted dental plans, nor make treatment recommendations based on plan allowances. We do not guarantee dental plan reimbursement. In the event there is an unpaid balance on your account, it will be subject to a monthly interest charge of 1.5% *regardless of outstanding insurance claims.* The responsible party accepts financial responsibility for all charges incurred as well as any fees associated with collecting any unpaid balance, including court costs, attorney fees, or any other related expenses. Please let us know if you have any questions about this policy.

I, the undersigned, affirm that I have read this document, understand the office policies as stated, and that the information provided by me is accurate.

Patient Signature:	**Date:**
Responsible Party Signature (if different from patient):	**Date:**

Medical Information

Last Name:	First Name:	MI:

Are you currently under the care of a physician?	**YES NO**
If "YES", please list the name and contact numbers for all treating physicians:	
Have you been hospitalized within the past 5 years?	**YES NO**
If "YES", please list the reason(s) for your hospitalization(s):	
Females: Are you pregnant, nursing or planning a pregnancy in the near future?	**YES NO**
Please list all over-the-counter (non-prescription) medications that you take:	
Please list all prescription medications that you take:	
Do you take anticoagulants/blood thinners?	**YES NO** ***If "YES", which one?***
Please indicate which herbal supplements you take: **ECHINACEA GARLIC GINGER GINSENG ST. JOHNS WORT FEVERFEW VITAMIN E KAVA VALERIAN GINGKO OTHER (PLEASE LIST):**	
Do you consume grapefruit products (fruit, fruit juice, juice extract)?	**YES NO**
Do you take antacids?	**YES NO** ***If "YES", which one?***
Please indicate if you have previously had any of these cosmetic services?	**BOTOX JUVADERM BOTH NEITHER**
Please indicate if you have any allergies to the following:	**PENICILLIN CODEINE LOCAL ANESTHETIC LATEX ASPIRIN**
Please list any additional allergies that you have:	
Are you a smoker/tobacco user?	**YES NO** ***If "YES", how much per day?***
How often to you drink alcoholic beverages?	**NEVER OCCASIONALLY DAILY**
Have you been previously treated for substance abuse?	**YES NO**

Your health is important to us. Please indicate if you have had any of the following:

Heart Murmur/MVP	**YES NO**	Hepatitis	**YES NO** ***If "YES" Type:***
Anemia	**YES NO**	Rheumatic Fever w/ Valve Damage	**YES NO**
Thyroid Disease	**YES NO**	Organ Transplant	**YES NO** ***If "YES", Organ:***
Tuberculosis (TB)	**YES NO**	Heart Surgery w/ Prosthetic Valve	**YES NO**
Lung Disease	**YES NO**	Kidney Disease	**YES NO**
Asthma	**YES NO**	Heart Surgery/Attack/Disease	**YES NO**
Sickle Cell Anemia	**YES NO**	Pacemaker	**YES NO**
Diabetes	**YES NO** ***If "YES" Type:***	High Blood Pressure	**YES NO**
Cancer	**YES NO** ***If "YES" Type:***	Stroke	**YES NO** ***When:***
Abnormal Heart Condition	**YES NO If "YES", *Explain:***	Bleeding Disorder/Clots	**YES NO**
Liver Disease/Jaundice	**YES NO**	Epilepsy	**YES NO**
Venereal Disease	**YES NO**	HIV+/AIDS	**YES NO**
Emphysema	**YES NO**	Stomach/Intestinal Disease	**YES NO**
Sore/Enlarged Lymph Nodes	**YES NO**	Previous Biopsies	**YES NO** ***If "YES", Explain:***
Recurrent Illnesses	**YES NO** ***If "YES", Explain:***	Other Infections	**YES NO**
Glaucoma	**YES NO**	Artificial Joints	**YES NO** ***If "YES", Location:***
Physical or Mental Disability	**YES NO**	Other artificial implants/devices	**YES NO** ***If "YES", Location:***

Please list any other medical conditions you have:

Name of former dentist:		Approximate date of last dental visit:	
Reason for today's visit:			
Do you request nitrous oxide (dental gas) for treatment?	**YES NO**	Would you like to be sedated for dental treatment?	**YES NO**
Do you have any special concerns regarding your dental care?		**YES NO** ***If "YES", Explain***	
How do you feel about your smile?			
Patient/Guardian Signature:		**Date:**	

MEDICAL INSURANCE INFORMATION			
Policyholder Last Name:		First Name:	MI:
Relationship to Patient: SELF SPOUSE PARENT STEP-PARENT OTHER:			
Physical Address:		City/State/Zip:	
Mailing Address (if different)		City/State/Zip	
Home Phone:	Work Phone:		Cell Phone:
Email Address:			
Date of Birth: / /	Gender: M F		SS#:
Employer/Plan Name:	Group #:		Member ID#:
Insurance Co. Name:		Insurance Co. Phone:	
Insurance Co. Address:		City/State/Zip:	
Are we authorized to release necessary information to your Medical carrier for claims processing purposes? YES NO			
Do you authorize your Medical carrier to issue payment directly to our office? YES NO			