Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Patient Name:____ Date:__________
Last, First MI (Preferred Name)

Email:____ Gender: ____ Family Status: ________

Social Security #: ______________________ Birth Date: ____________________

Phone (Home): _______________ (Cell):______________ (Work):_________________ Ext: _______________

Address: ____
Street Apartment #

____
City State Zip Code

Person to contact in case of emergency: Name:_________________________Phone:___________________
Address:____

Health Information

Reason for **TODAY'S** visit: ________________ Date of **LAST** dental visit: ____________________________

Date of **LAST** dental xrays:_________________ Pharmacy Name:____________________Phone:_________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies __________ __________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Chemical Dependency
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Habit
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _________________
- ☐ _________________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- List medications you are currently taking:____
  ____
- Name of Physician: ____ Phone: __________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

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

____ Date: ____________________
Signature of patient, parent or guardian

How would you like to be contacted:

Home phone____ Cell Phone____ Text___ Email ___ Other _________________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____ Birth Date: ______________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: __________________ Email: ________________________________

Phone (Home): ______________ (Cell): ______________ (Work): ______________ Ext: ______

Address: ____
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: ______________________

Address: ____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: __________________ Group #: ________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: __________________ Group #: ________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Insurance Plan Name and Address: ____

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Consent for Services

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information.

I have received and understand your *Office Policy*.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ___________ Relationship to Patient: ________________
Signature of patient, parent or guardian/responsible party