

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The more you communicate to us, enables us to better care for you.

Today's Date: _____ E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo # _____

City State Zip

Single Married Divorced Widowed Separated

Home Phone: (____) _____ Cell: (____) _____

Work Phone: (____) _____ Ext: _____ Other #: _____

Person Responsible for Account:

Name: _____

Employer: _____ Driver's License #: _____

Work Phone: (____) _____ Home Phone: (____) _____

Relationship: _____ Social Security #: _____

Billing Address: _____

In the event of an emergency, whom should we contact?

His / Her Name: _____ Relation: _____

Work Phone: (____) _____ Home Phone: (____) _____

PRIMARY INSURANCE **Dental Insurance?** Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

MEDICAL HISTORY

Are you currently under medical treatment? YES NO

If yes, explain _____

Have you ever had any serious illness or operations? YES NO

If yes, explain _____

List any medications that you are currently taking:

List any known drug allergies:

Have you ever taken Fosamax (bisphosphonates) for osteoporosis treatment? YES NO

Do you have any medical condition requiring you to routinely take antibiotics before ANY dental treatment (heart defect, artificial valve or artificial joint)? YES NO

Women, are you: PREGNANT NURSING TAKING BIRTH CONTROL

Reason for today's visit: _____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

Signature _____

Date _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

My method of payment will be _____

Signature _____

Date _____

Thank you for filling out this form completely. If you have any questions at any time, please ask us. Payment is due in full at the time of treatment unless prior arrangements have been approved.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA