New Patient Welcome To Our Office 2015

Today's Date: _____

Reason for visit today? _____

Patient Name: _____ _____ ____
(Last) (First) (M)

Preferred Name: _____

Home Address:

_____
PO Box (if applicable) Physical Address Required

_____
City State Zip Code

Birthdate: ____/_____/____ SS# _____-_____-_____

Circle: Male Female Age: _____
Single Married Divorced Widowed Separated

Other Family Members Seen By Us: _____

Circle Last Dental Cleaning: 6mths 6mths-1yr 1-2yrs over 2yrs

Contact Information: (We offer Text and Email Confirmation)

Home# (____)_____ Cell# (_____)_____ Work# _____

Email Address: _____@_____

Whom May We Thank For Referring You? Internet , Postcard In Mail,

Friend/Relative Name: _____

Medical

Physicians Name: _____ Phone: (_____) _____

Date of Last Visit? ____/_____/_____

Medical History: Circle Yes or No

Yes/No Abnormal Bleeding Yes/No High Blood Pres.
Yes/No Broken Jaw Yes/No Ulcer/Colitis
Yes/No Diabetes Yes/No Difficulty Breathing
Yes/No Drug/Alcohol Abuse Yes/No **Stroke**
Yes/No Emphysema/Glaucoma Yes/No Asthma/ Arthritis
Yes/No Hepatitis A/B/C Yes/No Sinus Problems
Yes/No HIV +/AIDS Yes/No Kidney Disease
Yes/NoTuberculosis Yes/No Liver Disease
Yes/No Epilepsy/Seizures/Fainting
Yes/No Psychiatric Problems Yes/No Venereal Disease
Yes/No Congenital Heart Defect Yes/No Gum Disease
Yes/No Artificial Joints/Valves
☐**Heart Surgery/Pace Maker** ☐**Heart Attack** **Date** _____
Yes/No Smoke/Tobacco Use Other Health Prob. _____
Cancer/Chemotherapy (if so, When _____
Any Recent Surgery's: _____

For WOMEN: Are you taking birth control pills? ___
Are You **PREGNANT**? ☐Yes ☐No Week # _____
Are You Nursing? ☐Yes ☐No

Are You **ALLERGIC** to any of the following? Yes / No
☐Aspirin ☐Codeine ☐Penicillin
☐Erythromycin ☐Tetracycline ☐Latex
☐Dental Anesthetics ☐Metals ☐Other
Please list OTHER DRUG ALLERGIES:_____
_____
MEDICATIONS you are taking: _____
_____
_____

Person Responsible For Account:
if minor; parent who attends child today)
Name:

_____
Last First M.I.

Address:

_____
PO Box (If Applicable) Physical Address Required

_____
City State Zip Code

Insurance Information:
Insured's Name: _____
Insured's Employer: _____
Employer Address: _____
Insured's Birthdate: _____/_____/_____ SS# _____/_____/_____
Insured's ID # _____
Insurance Co. Name: _____
Insurance Address: _____
Complete address (PO Box or Physical, City, State, Zip Code)
Group # _____ Phone # (_____) _____

Basic Information About How Our Office Handles Insurance:
As a courtesy to our patients, our office will file all dental insurance claims and give assistance to make sure that your insurance pays to the maximum. We must have all pertinent insurance information.
Our office is not a NETWORK PROVIDER FOR ANY INSURANCE PLAN.
Any unpaid insurance balance over **45 days** becomes the patient responsibility. All co-payments are due **at Time of Service**. If you have any questions, please see Insurance Billing.

No Insurance… No Problem!
Ask about our Dental Health Club Plan!
Yearly Membership with Savings
No Maximums, No Deductible

I understand the information I have given today is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____