Chart #: _____
FOR OFFICE USE ONLY

About You

Today's Date: _____ / _____ / _____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ • Male • Female

Birthdate: ___ / ___ / ___ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: • Minor • Single • Married • Divorced • Separated • Widowed

Spouse's Name: _____

Do you have children? • Yes • No How Many? _____

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

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

Insured's Name: _____

Relation: _____

Date of Birth: _____/ _____ /_____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Insured's ID#: _____

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

Insured's Name: _____

Relation: _____

Date of Birth: _____ /_____ /_____

Insured's Employer: _____

Account Information

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (____) _____

Payment Method: • Cash • Check

_____ ___ / ___

• Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am soley responsible for any balance not paid by my insurance company (if offered at this office).
Initials

In Event of Emergency

Whom should we contact? _____

Relation: _____

Home #: (____) _____

Work #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

Health Information

◯Aids	◯Dizziness	◯Hepatitis	◯Respiratory Problem
◯Allergies	◯Epilepsy	◯High Blood Pressure	◯Rheumatic Fever
◯Anemia	◯Excessive Bleeding	◯Kidney Disease	◯Sinus Problems
◯Arthritis	◯Fainting	◯Liver Disease	◯Sinus Problems
◯Artificial Joints	◯Glaucoma	◯Mental Disorders	◯Stomach Problems
◯Asthma	◯Hay Fever	◯Nervous Disorders	◯Stroke
◯Blood Disease	◯Head Injuries	◯Pacemaker	◯Tuberculosis
◯Cancer	◯Heart Disease	◯Pregnancy _____	◯Tumors
◯Diabetes	◯Heart Murmur	◯ Radiation or Chemo	◯Ulcers

◯ Medication Allergies please list

_____

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 treatment during the past two years? ◯ yes ◯no

If yes please explain _____

Are you under the care of a physician? ◯yes ◯ no Name of Physician: _____

Are you taking osteoporosis meds at this time? ◯yes ◯ no _____

Do you have any health problems not listed above? _____

Please list any medications or herbal supplements you are taking at this time: _____

_____

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

Signature of patient _____ Date _____

Referral Information

Whom may we thank for referring you to our office? ◯ Another patient, friend ◯ Another patient, relative ◯ Dental Office
◯ Yellow Pages ◯ School ◯ Dental ins ◯ Website / Facebook ◯ Other _____

Name of person referring you to our office :_____

A$25.00 fee will be enforced for all missed appointments without a 24 hour notice. Appointments over one hour in length may be assessed an additional $25.00 . Please Initial _____