

Thank you for trusting us with your dental care.
We promise to do our best to provide you with
the finest care available. If you have any
questions please do not hesitate to call us.

State				Patient #		
Second S						
Birthdate			Date			
State Zip	PATIENT	INFORMA	TION			
State	Name			Birthdate	Home Phone ()	
Separated Divorced Partnered for	Address			City	State Zip	
Separated Divorced Partnered for	10.000000000000000000000000000000000000	☐ Married	Widowed	☐ Single ☐ Minor		
Employer/School Address			Divorced	Partnered foryears		
Employer/School Address	E-mail	The second of th	Cell Phone #	1()	Cell Phone #2 ()	
Employer/School Address	Employer/School			Employer/School Pho	ne ()	
Spouse or Parent's Name						
Whom may we thank for referring you? Person to contact in case of emergency RESPONSIBLE PARTY Name of Person Responsible for this Account. Relation to Patient Home Phone () Birrhdate Cell Phone () LNSURANCE INFORMATION Name of Insured Birrhdate Social Security # Date Employed Employer Work Phone () Employer Address City State Zip Insurance Company Address City Address Relation to Patient Birrhdate Social Security # Date Employed Employer Work Phone () State Zip How much is your deductible? How much have you used? ADDITIONAL INSURANCE Name of Insured Relation to Patient Birrhdate Social Security # Date Employed Employer Max. Annual Benefit Date Employed Employer ADDITIONAL INSURANCE Name of Insured Relation to Patient Birrhdate Social Security # Date Employed Union or Local # Date Employed Employer Work Phone () Employer City State Zip Union or Local # Union or Local # Date Employed Employer Work Phone () Employer City State Zip Union or Local # Union or Local # Date Employed Employer City State Zip Union or Local # Date Employed						
RESPONSIBLE PARTY Name of Person Responsible for this Account. Relation to Patient Address Home Phone () Birthdate Bank Cell Phone () TNSURANCE INFORMATION Relation to Patient Birthdate Social Security # Date Employed Employer Address City State Zip How much have you used? ADDITIONAL INSURANCE Birthdate Social Security # Date Employed Brelation to Patient Date Employed Brank ADDITIONAL INSURANCE Relation to Patient Date Employed Brank Brank Cell Phone () State Zip Union or Local # Zip ADDITIONAL INSURANCE Relation to Patient Date Employed Brank Brank Cell Phone () Brank Cell Phone () Date Employed Brank Zip Address City State Zip Date Employed Max. Annual Benefit Date Employed Work Phone () Brank Date Employed Wark Phone () State Zip Date Employed Date Emplo						
RESPONSIBLE PARTY Name of Person Responsible for this Account. Address Driver's License # Birthdate Bank Employer Work Phone () Currently a patient in our office? Ves No E-mail Cell Phone () INSURANCE INFORMATION Name of Insured Relation to Patient Birthdate Social Security # Date Employed Employer Address City State Zip Insurance Company Group # Union or Local # ADDITIONAL INSURANCE Name of Insured Relation to Patient Birthdate Social Security # Date Employed Employer Address City State Zip Max. Annual Benefit ADDITIONAL INSURANCE Relation to Patient Date Employed Employer State Zip Max. Annual Benefit Date Employed Employer Group # Date Employed Employer State Zip Max. Annual Benefit ADDITIONAL INSURANCE Relation to Patient Date Employed Employer Group # Date Employed Employer Group # Date Employed Employer Group # Date Employed Employer Address City State Zip Insurance Company Group # Union or Local # Zip Insurance Company Group # Union or Local # Zip Address City State Zip Union or Local # Zip Address City State Zip Union or Local # Zip Address City State Zip Union or Local # Zip Address City State Zip Union or Local # Zip Address City State Zip Union or Local # Zip						
Name of Person Responsible for this Account Relation to Patient Replacement Home Phone (
Relation to Patient Address Home Phone () Birthdate	STREET, STREET, SQUARE, SQUARE	SIBLE PAI	RTY			
Address Home Phone () Driver's License # Birthdate Bank Employer Work Phone () LINSURANCE INFORMATION Name of Insured Relation to Patient Birthdate Social Security # Date Employed Employer Address City State Zip How much is your deductible? How much have you used? Max. Annual Benefit ADDITIONAL INSURANCE Name of Insured Social Security # Date Employed Employer Address City State Zip How much have you used? Max. Annual Benefit ADDITIONAL INSURANCE Name of Insured Social Security # Date Employed Employer Address City State Zip Max. Annual Benefit ADDITIONAL INSURANCE Name of Insured Relation to Patient Birthdate Social Security # Date Employed Employer Address City State Zip Insurance Company Group # Union or Local # Zip Insurance Company Group # Union or Local # Zip Insurance Company Group # Union or Local # Zip Address City State Zip Address City State Zip	The state of the s	Account		Relation to Patient		
Birthdate Bank Ba	Address	100.074.000		Home Phone ()		
Employer					Bank	
INSURANCE INFORMATION Name of Insured						
INSURANCE INFORMATION Name of Insured					Cell Phone ()	
Relation to Patient Birthdate Social Security # Date Employed Employer Work Phone () Employer Address City State Zip Insurance Company Group # Union or Local # Zip How much is your deductible? Haw much have you used? Max. Annual Benefit ADDITIONAL INSURANCE Relation to Patient Birthdate Social Security # Date Employed Employer Work Phone () Employer Address City State Zip Max. Annual Benefit ADDITIONAL INSURANCE Relation to Patient Date Employed Zip Insurance Company Group # Union or Local # Zip Insurance Company Group # Union or Local # Zip Address City State Zip Address City State Zip State Zip Only State Zip Address Zip Address City State Zip Address Zip						
Birthdate Social Security # Date Employed Employer	INSURA	NCE INFO	RMATION			
Employer	Name of Insured			Relation to Patient		
City	Birthdate Social Secu			nty#	Date Employed	
Insurance Company Group # Union or Local # Address City State Zip How much is your deductible? How much have you used? Max. Annual Benefit ADDITIONAL INSURANCE Name of Insured Relation to Patient Birthdate Social Security # Date Employed Employer Work Phone () Employer Address City State Zip Insurance Company Group # Union or Local # Address City State Zip Address City State Zip Address Zip Address City State Zip	Employer			Work Phone ()		
Address City State Zip	Employer Address			City	42VW	
How much is your deductible? How much have you used? Max. Annual Benefit ADDITIONAL INSURANCE Name of Insured Relation to Patient Birthdate Social Security # Date Employed Employer Work Phone () Employer Address City State Zip Insurance Company Group # Union or Local # Address City State Zip	Insurance Company			Group #	Union or Local #	
ADDITIONAL INSURANCE Name of Insured	Address			City	State Zip	
ADDITIONAL INSURANCE Name of Insured Relation to Patient Birthdate Social Security # Date Employed Employer Work Phone () Employer Address City State Zip Insurance Company Group # Union or Local # Address City State Zip	How much is your deductible? How much ha			nave you used?	Max. Annual Benefit	
Name of Insured						
Birthdate	ADDITI	ONAL INS	URANCE			
Employer	Name of Insured	Name of Insured Relation to Patient			41 - 1111	
Employer Address City State Zip Insurance Company Group # Union or Local # Address City State Zip	Birthdate Social Secu		rity#	Date Employed		
Insurance Company	Employer			Work Phone ()		
Address City State Zip					State Zip	
Address City State Zip	Insurance Company			Group #	Union or Local #	
The second of th	Address				State Zip	
	How much is your deductible? How much have you used?				Max. Annual Benefit	

DENTAL HISTORY Reason for today's visit_ Date of last dental care Former Dentist Date of last dental X-rays Address Check (✓) if you have had problems with any of the following: Sensitivity to hot Bad breath Grinding teeth Loose teeth or broken tillings Sensitivity to sweets Bleeding gums Periodontal treatment Sensitivity when biting Clicking or popping jaw Sensitivity to cold Sores or growths in your mouth Food collection between the teeth How often do you fioss? How often do you brush? MEDICAL HISTORY Date of last visit Physician's Name Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). [Yes Have you had any serious illnesses or operations? Yes No If yes, describe Have you ever had a blood transfusion? Tyes If yes, give approximate dates Taking birth control pills? Yes No (Women) Are you pregnant? Yes No Nursing? Yes No Check (✓) if you have or have had any of the following: ☐ Anemia Congenital Heart Lesions Hepatitis Scarlet Fever Arthritis, Rheumatism Cortisone Treatments Hernia Repair Shortness of Breath High Blood Pressure Skin Rash Artificial Heart Valves Cough, Persistent HIV/AIDS Artificial Joints, Pins, etc. Cough up Blood Stroke Diabetes Jaw Pain Swelling of Feet or Ankles Asthma ☐ Kidney Disease Thyroid Problems ☐ Back Problems Epilepsy Bleeding Abnormally Liver Disease Tobacco Habit Fainting Blood Disease Glaucoma Mitral Valve Prolapse Tonsillitis Headaches Pacemaker ☐ Tuberculosis Cancer Chemical Dependency Heart Murmur ☐ Radiation Treatment ☐ Ulcer Heart Problems Respiratory Disease Venereal Disease Chemotherapy Rheumatic Fever Circulatory Problems Hemophilia List medications you are currently taking and the correlating diagnosis: Allergies: AUTHORIZATION AND RELEASE To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to Name of Insurance Company(ies) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(jes) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below. Date Signature of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient