Family Dentistry!

About You

Date: ________ Name: ________________

Birthdate: ____________ Male Female

SS#: __________________ Age: ________

Home Address: ______________________
__________City:__________Zip:_______

Home Phone #: ____________________
Work Phone #: ____________________
Cell Phone #: ____________________
E-mail: __________________________
Status: Single, Married, Divorced, Separated

Spouse's Name: ____________________

Referred By: ______________________

Insurance Information

Dental Ins. Co.:
____

Insurance Co. Phone #:
____

Group/ Policy #: __________

This Dental Insurance is provided through:
Policy owner's name:
____

Policy owner's SS #:
____

Policy owner's birthdate:
____

Policy owner's employer:
____

*if secondary insurance, please ask for additional form.

Occupation

Occupation: ________________

Employer: ________________

Employer's Address:
____
____

Work Phone:
______________EXT:______

In Event of Emergency

Whom should we contact?
____

Relation: ______________
Home Phone:
____

WorkPhone:
________EXT:____
Who is your Medical Dr.?
____

Dr.'s
Phone#:______________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA and the ADA.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

____
(Signature)

____
(Date)

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Medical History:
Please Circle the ones that apply to you.

1. Are you taking any of the following medications?

- ☐ Pain Killers (including aspirin)
- ☐ Muscle Relaxers
- ☐ Stimulants
- ☐ Nerve Pills
- ☐ Blood Thinners
- ☐ Tranquilizers
- ☐ Insulin
- ☐ Others: ______________________

____

2. Are you allergic to any of the following?

- ☐ Latex
- ☐ Penicillin/ Amoxicillin
- ☐ Tetracycline
- ☐ Aspirin
- ☐ Dental Anesthetics
- ☐ Others:

____

____

3. Do you have or have you had any of the following diseases, medical conditions or procedures?

- ☐ Heart Attack/ Stroke
- ☐ Heart Surg./Pacemaker
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Artificial Valves
- ☐ Heart Disease
- ☐ Congenital Heart Defect
- ☐ Chest Pains
- ☐ Scarlet Fever
- ☐ Nervousness
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stomach Problems/ Ulcers
- ☐ Psychiatric Problems
- ☐ Venereal Disease
- ☐ Alcohol/Drug Abuse
- ☐ Tuberculosis "TB"
- ☐ Jaw Problems TMJ/TMD
- ☐ Cancer/Tumors
- ☐ Shingles
- ☐ Hepatitis
- ☐ HIV+/AIDS/ARC
- ☐ Arthritis/ Rheumatism
- ☐ Artificial Bones/Joints
- ☐ Emphysema
- ☐ Fainting/Seizures/Epilepsy
- ☐ Severe/Frequent Headaches
- ☐ Frequent Neck Pain
- ☐ Back Problems
- ☐ Cosmetic Surgery
- ☐ X-ray or Cobalt
- ☐ Chemotherapy
- ☐ Asthma
- ☐ Difficulty Breathing
- ☐ Diabetes/Hypoglycemia
- ☐ Leukemia
- ☐ Anemia
- ☐ High/Low Blood
- ☐ Pressure
- ☐ Bleeding problems
- ☐ Glaucoma

4. Other Questions:

Do you use tobacco? ☐
How used? ______________
How Often/Much? ______________
How Long? __________

Questions For Women
Are you taking birth control pills? ☐
Are you pregnant? ☐
How Long? ______________
Are you nursing? ☐
Additional Doctor: ______________

5. Please list any other surgeries or medical conditions you have or ever had:

____

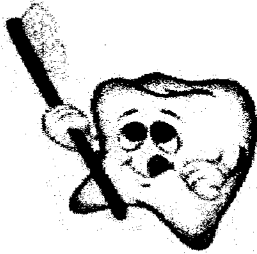
____

____

Update *Office Use Only	
initials	date
initials	date
initials	date
initials	date
initials	date
initials	date

- We invite you to discuss with us any questions regarding our services. The best Dental health services based on a friendly, mutual understanding between provider and patient.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ______________________ Date: __________



Insurance Agreement

To our patients who are requesting that this office carries a balance on their account, to be paid by an insurance company.

This form must be read and signed by the patient or responsible party before we can accept payment directly from an insurance company.

1) I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to pay within 90 days I will be responsible for the full amount.

2) I understand and agree that the amount estimated to remain unpaid by insurance is to be paid by me during treatment.

3) I understand that this office cannot make a totally accurate estimate of the insurance benefits to be paid for me, since it does not have access to all insurance company records.

4) I understand that after the insurance company pays, there could be a balance still remaining to be paid to me.

5) I understand and agree that if upon payment by the insurance company, there is a remaining balance; it is due to be paid in full by me at that time.

Signature: ________________________________ Date: ________

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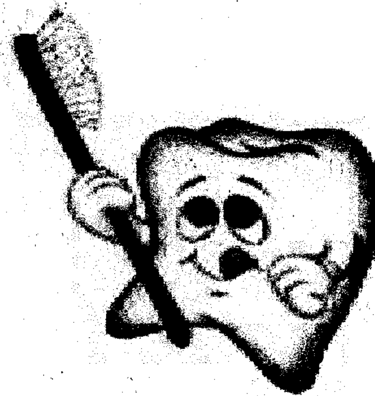
Our mission is to deliver the finest, most cost-effective healthcare treatment available today. Following diagnosis, the doctor will advise you of the recommended treatment plan. In addition, we will discuss with you the cost of today's visit and the cost of future treatment.

Payment for services is due and payable at the time the services are rendered. We are sensitive to the fact that some people may not be able to pay cash for their treatment; therefore, we offer several alternative payment programs for your convenience. They are:

1. Cash or Check (with Bank Guarantee Card)
2. Visa or MasterCard
3. American express
4. Discover
5. Care credit



Appointment times are reserved specifically to meet your needs. If for any reason you are unable to keep your reserved appointment time, 24-hour advance notice is required to avoid being charged. Broken appointment fees vary between $20.00 - $75.00.

Signature: ________________________________ Date: ________