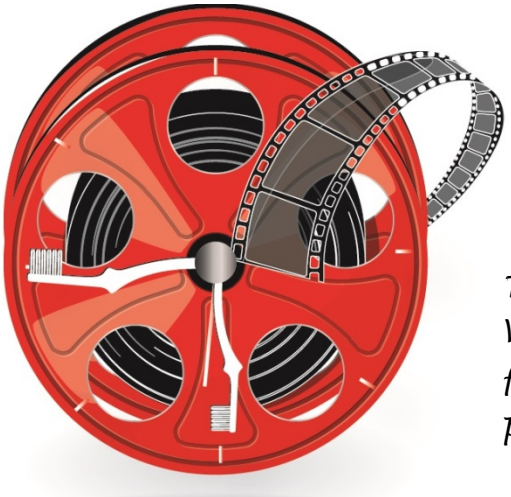

Welcome

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.

Patient Information

Name _____DOB_____ Home Phone: _____
Address: _____ City_____ State_____ Zip_____
Sex: (circle) Male Female Married Widowed Single Minor Separated Divorced
Social Security #:_____Email_____ Cell Phone#:_____
Patients' Employer/School: _____ Phone#:_____
Spouse or Parent Name: _____ Spouse or Parent Employer: _____
Whom may we thank for refereeing you? _____
Person to contact in case of emergency_____ Phone#:_____

Responsible Party

Name of Person Responsible for this account: _____ Relation to patient:_____
Address: _____ Home Phone: _____
Driver's License #: _____ DOB _____ Social Security #: _____
Employer: _____Work Phone#: _____Cell Phone #:_____
Currently a patient in our office? _____ Email: _____
Dental Insurance Company: _____Subscriber Name: _____

Dental History

Reason for today's visit? _____ Date of last dental Care: _____
Former Dentist: _____ Date of last Dental X-rays: _____

Circle if you have had problems with any of the following:

Bad Breath	Grinding of teeth	Sensitivity to hot
Bleeding gums	Loose teeth of broken fillings	Sensitivity to sweets
Clicking or popping jaw	Periodontal Treatment	Sensitivity when biting
Food collection between the teeth	Sensitivity to cold	Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____ Are you happy with your smile?

_____
If you answered no, what would it take to correct it? _____

Refer friends and family, get rewarded. (Ask us how.)

Referral #1	*Referral#2*	*Referral #3*
Name: _____	*Name:* _____	*Name:*
_____		
*Phone #:*_____	*Phone#:* _____	*Phone#:*
_____		

Review our office on yellowpages.com to receive 5%OFF Also, Check in on to Facebook from our office to receive an extra 5%OFF Treatment.

Medical History

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). (Circle) Yes No

Have you had any serious illnesses or operations? Yes No If yes, describe_____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates: _____

(Women) Are you pregnant? Yes No Trimester? _____ Nursing? Yes No Taking birth control? Yes No

Patients with Medical Conditions such as Diabetes may be charged for accurate Blood sugar level readings that may not be covered by your insurance. By signing below you are aware of this fee. To avoid being charged a fee, you are able to bring your own Glucometor to your Dental visit.

Circle if you have or have had any of the following:

Anemia	Cortisone Treatments	Hernia Repair	Venereal Disease
Arthritis/Rheumatism	Cough, Persistent	High Blood Pressure	
Artificial Heart Valves	Cough up Blood	HIV/AIDS	
Asthma	Diabetes	Jaw Pain	
Back Problems	Epilepsy	Kidney Disease	
Bleeding Abnormally	Fainting	Liver Disease	
Blood disease	Glaucoma	Mitral Valve Prolapse	
Cancer	Headaches	Pacemaker	
Chemical Dependency	Heart Murmur	Radiation Treatment	
Chemotherapy	Heart Problems	Respiratory Disease	
Circulatory Problems	Hemophilia	Rheumatic Fever	
Congenital Heart Lesions	Hepatitis	Scarlet Fever	
Shortness of Breath	Skin Rash	Stroke	
Swelling of Feet or Ankles	Thyroid Problems	Tobacco Habit	
Tonsillitis	Tuberculosis	Ulcer	

List Medications you are currently taking

_____

_____

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 Dr. Smith 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 (ies) 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 complicated or one year from the date signed below.

_____ _____ _____

Signature of Patient/ Guardian or Personal Rep Date Please Print Name

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