PATIENT INFORMATION FORM

Name _____ Date _____

Date of birth _____ If a minor, parent's name _____

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Address _____ Home phone _____

City _____ State _____ Zip Code _____

Employer _____ Work phone _____

Occupation _____ How long? _____

Name of spouse _____

Occupation _____ Employer _____ How long? _____

Primary Dental insurance carrier_____Group # _____

Subscriber's name_____Birthdate _____

Social Security number _____

Secondary Dental insurance carrier_____Group # _____

Subscriber's name_____Birthdate _____

Social Security number _____

* Nitrous Oxide(laughing gas) is available upon request for $60.00.

OFFICE FINANCIAL POLICY

Fees or estimated co-payments must be paid in full at the time of treatment.
Please indicate your preferred method of payment:

❑ CASH ❑ VISA, MASTERCARD ❑ CHECK ❑ CARE CREDIT

All information is true and complete. The undersigned agrees to be responsible for all fees (and co-payments) for services rendered in the office.

SIGNATURE X_____ DATE_____

OVER →

If dental insurance applies: This office accepts your insurance and files claims as a courtesy service to you. However, we are not a contracted provider with several insurance companies. The insurance contract is between you and your insurance company. As we have no control over the insurance company's method or amount of payment, any difference of payment is entirely your responsibility.

We value your trust and appreciate your commitment to dental care.

PATIENT INFORMATION FORM

1. The name of my dentist is _____
2. The name of my physician is _____
3. Are you now under the care of a physician? ..... YES NO
4. Have you had any serious illness or operation? ..... YES NO
5. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease ..... YES NO
   b. Heart murmur ..... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, angina, congestive heart failure, coronary artery disease.) ..... YES NO
   d. High blood pressure ..... YES NO
   e. Stroke ..... YES NO
   f. Allergy ..... YES NO
   g. Seizures ..... YES NO
   h. Asthma ..... YES NO
   i. Diabetes ..... YES NO
   j. Hepatitis, jaundice or liver disease ..... YES NO
   k. Arthritis ..... YES NO
   l. Stomach ulcers or intestinal problems ..... YES NO
   m. Kidney disease ..... YES NO
   n. Tuberculosis ..... YES NO
   o. AIDS ..... YES NO
   p. Venereal disease ..... YES NO
   q. Anemia or Hemophilia ..... YES NO
   r. Frequent or severe headaches ..... YES NO
   s. Have you had eye, ear, nose, sinus problems ..... YES NO
   t. Cancer, Chemotherapy, Radiation Therapy ..... YES NO
   u. Do you clench/grind your teeth, perhaps in your sleep ..... YES NO
   v. Jaw problems (TMD) ..... YES NO
6. Do you have any allergies? ..... YES NO
   If so, what? _____
   Do you have any further health concerns or additional information ..... YES NO
   If yes, please specify _____
7. Have you had abnormal bleeding associated with previous extraction, surgery, or trauma? ..... YES NO
8. Please list all medications you are currently taking: _____

_____

9. Women: Are you pregnant? ..... YES NO
10. Women: Are you nursing? ..... YES NO

I certify that the above information is correct.

Name X _____