WELCOME!

1. PATIENT INFORMATION

TODAY'S DATE:_______________

Name: ________________________________Birthdate:__________ SSN:______________

Home Phone: (______)______________ Cell: (______)_______________

_Married _Single _Widowed _Divorced _Separated _Other

Address: ____

____

Employer: ________________________ Work Phone: ________________________

Emergency contact: _____________________ Phone:(__)___________________

Referred by:

2. RESPONSIBLE PARTY (IF DIFFERENT FROM SELF)

Name of person Responsible for this Account: ______________________________

Relationship to Patient: ____________________________ Birthdate: ________

SSN: __________________ Email: _____________________________

3. DENTAL INSURANCE (PRIMARY/SECONDARY)

PRIMARY SECONDARY

Insured Name: ________________ Relationship to Patient: ______________ Birthdate: ________

SSN: __________________ Employer: ________________ Ins. Co Name: ________________

Group#: ____________ **(IF Secondary)** Insured Name: _____________________ Birthdate: _________
SSN: ______________ Group#: _____________ Employer: ____________________

4. MEDICAL HISTORY

Physicians Name: ______________________ Telephone#: _____________________

Are you currently under the care of a Physician? Yes/No Date of Last visit: ___________

Do you **Pre-Med** before dental appointment? Yes/No, If yes (explain) ______________________

Have you been hospitalized or had a serious illness within the past five years? Yes/No

(explain):____

Have you ever had blood transfusion? Yes/No (if yes give date)______________________

(Women) Are you pregnant or is it likely that you could be pregnant? Yes/No

Circle if you have or ever had:

Artificial limb/joint/hip	Chemical Dependency	Mental Illness	Thyroid disease
Alzheimer's Disease	Dementia	Osteoporosis	Tobacco Habit
Anemia	Diabetes	Osteopenia	Tuberculosis
Asthma	Defibrillator	Pacemaker	Ulcer
Artificial Heart Valve	Epilepsy/Seizures	Parkinson's Disease	Liver problems
Arthritis/Rheumatism	Headaches/injury	Radiation Treatment	
Bleeding Abnormal	Heart murmur	Respiratory Disease	
Bell's Palsy	Heart problems	Scarlet Fever	
Blood thinners	HIV/AIDS	STD	
Chemical dependency	High Blood Pressure	Shortness of Breath	
Cough up Blood	Hepatitis (A, B, or C)	Stroke (TIA)	
Cancer (what type)	Kidney Disorder	Swelling feet/ankles	

List of Medications you are currently taking or any known ALLERGIES (ex: Penicillin):
____
____
____ Provided office with separate list of meds.

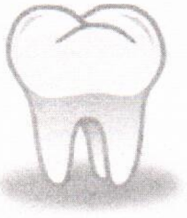
5. AUTHORIZATION AND RELEASE

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with this claim**. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity, Dr. Name or Dental Entity: _______________________________________**

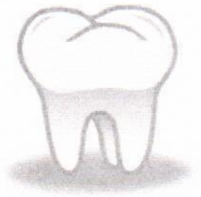
____ Date: ______________________________
(Signature of Patient, Parent, Guardian or Responsible Party)

____ Date: ______________________________
(Please Print name of Patient, Parent, Guardian or Responsible Party)

Dentist Signature:____________________



Existing Patient Update Form



Please complete this Patient Update and return it to the Front Desk.
We're glad you're here again!

Patient Information

Full Name: ____________________
Preferred Name: ____________________
Address: ____________________
____
DOB: ____________________

Marital Status (please circle) S M D W
Spouse Name: ____________________ *

Home #__________ Cell #__________
Work #__________ Other #__________
Email Address____________________

In Event of Emergency

Whom should we contact ____________________
Relation ____________________
Home #__________ Cell #__________

Who is your Medical Doctor ____________________
Medical Doctor's Phone #

Account Information

Please indicate your Payment Method for Services;
______ Fee for Service (Cash, Check, Charge)
______ Private Insurance
______ Medicaid

***Please notify our receptionist if your insurance carrier has chanaed.**

Medical History Update

1. Have there been any changes in your health since your last dental appointment....................YES NO
   a. If yes, for what conditions____________________
2. Are you taking any medications at this time....................YES NO
   a. If yes, please list them____________________
3. Do you have any allergies or adverse reactions to any medications....................YES NO
   a. If yes, please explain____________________
4. *Women*, Are you currently pregnant....................YES NO
   a. If yes, when is your due date ____________________
5. Is there anything we need to know about your health that is not listed above....................YES NO
   a. If yes, please list____________________

Even if there has been NO change in your health history, please sign & date this form to be made part of your chart.

Guarantee of Account

I guarantee full payment of all dental charges incurred by the above patient. I give my consent to needed dental services recommended for my (my minor) benefit and accept full responsibility of payment for services performed. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.

Signed: ______________________________ Date: ____________________
(Guardian must sign, if Patient under 18 years)