

Getting to know you and your smile...

About you

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Social Security Number _____

Home Address _____

Home Phone Number _____

Business Address _____

Business Phone Number _____

Let us know

Appointment time you prefer _____

Person responsible for account _____

Who referred you to us? _____

Former dentist _____ Last visit _____

Physician _____ Physician's phone _____

Last medical exam _____

Is this an emergency visit? Yes No

Are you in pain? Yes No

Your medical history

Have you been hospitalized in the last two years? Yes No

Are you allergic to any medication? Yes No

Are you allergic to any local anesthesia? Yes No

Are you presently taking any medications? Yes No

Do you have any circulation problem? Yes No

Have you ever had radiation therapy? Yes No

Have you had any of the following? If yes, please check the appropriate circle(s).

- | | | |
|------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------|
| <input type="radio"/> AIDS | <input type="radio"/> Artificial Joints | <input type="radio"/> Are you pregnant? |
| <input type="radio"/> Emphysema | <input type="radio"/> Asthma | <input type="radio"/> Are you unhappy with the way your teeth look? |
| <input type="radio"/> Kidney Disease | <input type="radio"/> Ulcer | <input type="radio"/> Are your teeth painful? |
| <input type="radio"/> Cancer | <input type="radio"/> Venereal Disease | <input type="radio"/> Do you clench or grid your teeth? |
| <input type="radio"/> Cardiac Pacemaker | <input type="radio"/> Epilepsy | <input type="radio"/> Any problems with chewing on either side of your mouth? |
| <input type="radio"/> Sinus Problems | <input type="radio"/> Arthritis | <input type="radio"/> Do your gums bleed? |
| <input type="radio"/> Heart Murmur | <input type="radio"/> Hepatitis | <input type="radio"/> Do you have problems with bad breath? |
| <input type="radio"/> Heart Trouble | <input type="radio"/> Diabetes | <input type="radio"/> Any other medical problems we should know? |
| <input type="radio"/> Herpes | <input type="radio"/> Mitral Valve Prolapse | |
| <input type="radio"/> High blood pressure | <input type="radio"/> Artificial Heart Valves | Please explain: _____ |
| <input type="radio"/> Rheumatic Fever | <input type="radio"/> Tuberculosis | _____ |
| <input type="radio"/> Prolonged bleeding due to slight cut | | _____ |
| <input type="radio"/> Anemia or other blood problem | | _____ |

Primary Dental Insurance? No Yes Carrier: _____

Are you covered by more than one policy? No Yes

If yes, please explain: _____

I hereby assign insurance benefits payable to the attending dentist. Signature _____ Date _____

Each dental insurance policy has its own benefits. To help you get the full benefits from your policy, our staff will assist you in both filing out and processing the forms. You, of course, are responsible for any and all charges not paid by your insurance carrier.

I understand that I am fully responsible for payments of this account. We reserve the right to subject any unpaid balances and any financial arrangements not honored to a one and one and a half (1-1/2) percent late charge per month or the maximum charge allowed by law with all expenses incidental to collection including reasonable attorney's fee and court costs.

Signature _____ Date _____