Patient Information

Patient Name: _____ **Preferred Name:** _____

Phone: (Home) _____ **E-Mail Address:** _____

Phone: (Work) _____ **Male** ❑ **Female** ❑

Pager/Cell Phone: _____ **Birth Date:** _____

Home Address: _____

City / State / Zip: _____

Please list other members of your immediate family who are patients in our office: _____

Health Information

Date of Last Dental Visit: _____ **Do you suffer from dental anxiety? Yes** ❑ **No** ❑

Are you currently pregnant? Yes ❑ **No** ❑ **If so, due date:** _____

Have you ever had any of the following? Please check all that apply:

AIDS / HIV	❑	**High/Low Blood Pressure**	❑	**Heart Disease**	❑	**Mental Disorders**	❑
Anemia	❑	**Joint Replacement**	❑	**Heart Murmur**	❑	**Fainting Tendency**	❑
Asthma	❑	**Chemical Dependencies**	❑	**Recent Surgery**	❑		
Pacemaker	❑	**Radiation Treatment**	❑				
Diabetes	❑	**Rheumatic Fever**	❑				
Epilepsy	❑	**Transplant / Prostheses**	❑				
Hepatitis	❑	**Allergy to Nickel**	❑				
Tuberculosis	❑	**Allergy to Latex**	❑				
Sinus Trouble	❑	**Prolonged Bleeding**	❑				

Please List

Drug Allergies: _____

_____

Medications: _____

_____

- **Have you ever had any complications or allergic reactions following dental treatment?**
  Yes ❑ **No** ❑ **If yes, please explain:** _____
- **Do you have any health problems that need further clarification: Yes** ❑ **No** ❑
  If yes, please explain: _____
- **Name of primary Physician:** _____ **Phone:** _____
- **Do you currently use tobacco products? Yes** ❑ **No** ❑ **If so, how long?** _____
- **Do you frequently have a bad taste in your mouth?** _____
- **Are you interested in lightening your teeth? Yes** ❑ **No** ❑
- **If you could change anything about your teeth, what would it be?** _____
- **Why did you leave your previous dentist?** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

We routinely use latex products for your safety. If you have a known sensitivity to latex products please notify us prior to being called back to the treatment room.

Insurance Information

Name of insured (Last, First MI.): _____ Is insured a patient? Yes ❑ No ❑

Insured's birth date: _____ Social Security #: _____ Group #: _____

Insured's employer name: _____

Patient's relationship to insured: Self ❑ Spouse ❑ Child ❑ Other: _____

Dental insurance company: _____

*Please read and sign to have our office file your insurance: I authorize the release of information to my insurance company for dental reimbursement purposes. Insurance company will send benefits to your home address.

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

Can we thank someone for referring you?

Family Member: _____

Coworker: _____

Friend: _____

Doctor:

Or did you find us on your own?

Our Website ❑

Southwest Bulletin ❑

Welcome Letter ❑

Direct Mail/Postcard/Brochure ❑

Consent for Services

We consider it a great privilege to have you as a patient in our practice. We will always strive to provide you with the friendliest, highest quality dental care possible. As our pledge to you we will always provide you with a written treatment plan to include the cost of any proposed treatment. Therefore, when you decide to have treatment completed you will understand you financial obligation and **payment in full will be required at the time services are rendered**.

For patients that carry dental insurance, if so desired, we will electronically file the proper insurance forms and request that your **dental benefits be sent directly to us**. Please understand that our relationship is with you and not your insurance company but, if needed, we will serve as your advocate in any disputes that may occur between you and your insurance provider.

If you have a dental emergency please know that we will do everything we can to see you immediately, we just ask that you call us at the first sign that you may be having a problem. Also, we strive to stay on schedule and book only a small number of appointments per day. Therefore, broken and missed appointments are very disruptive to our practice. Please if a conflict of schedule is unavoidable we ask that you give us at least two days advance notice. For missed or broken appointments we reserve the right to charge a $50 fee.

From time to time we may need to telephone you to discuss matters of appointment times and treatment. Please let us know if this is a problem. I have read and understand my rights under HIPPA. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____

Signature of patient, parent or guardian

Relationship to patient: _____