HOW DID YOU HEAR ABOUT OUR OFFICE? _____

REASON FOR TODAY'S VISIT _____

PATIENT _____ Date of Birth _____Age_____ Gender___
Last First MI

ACCOUNT HOLDER INFORMATION

Name _____ Date of Birth_____ Relationship to patient_____

Address _____City_____State_____Zip_____ Gender_____

Home phone #_____ Work phone #_____Cell phone #_____

Email address_____ Phone # for notifications_____

Emergency contact_____ Phone #_____ Relationship_____

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

- ☐ AIDS
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chew on One Side
- ☐ Clench or Grind Teeth
- ☐ Diabetes
- ☐ Difficult Extractions
- ☐ Donor Organs
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Head Injuries
- ☐ Heart Disease/Surgery
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Migraines
- ☐ Novocaine Allergy or Side Effects
- ☐ Pacemaker
- ☐ Pregnancy Due Date _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sensitive Gum/Teeth
- ☐ Sinus Problems
- ☐ Stomach or Intestinal Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other_____

Please list any medication allergies: _____

Please list any major operations: _____

Please list any complications from dental treatment: _____

Name of Physician: _____ Phone: _____

Please list current medications: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform you at the next appointment.

Signature of Patient (or Parent or Guardian if Minor) Date

FOR OFFICE USE ONLY: I have reviewed the Health Information.

_____ _____
Dentist Signature Date

INSURANCE INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

PRIMARY Insurance Company_____ Insurance phone_____

Group #_____ Relationship to Patient_____

Policy Holder's Name_____ Date of Birth_____

Social Security Number_____ Member ID _____

Employer_____ Work #_____

SECONDARY Insurance Company_____ Insurance phone_____

Group #_____ Relationship to Patient_____

Policy Holder's Name_____ Date of Birth_____

Social Security Number_____ Member ID_____

Employer_____ Work #_____

CONSENT FOR SERVICES

Please initial that you acknowledge the following statements:

____ I authorize treatment by the doctor and supporting staff members.

____ I understand there may be a charge of $35 for broken appointments without at least 24 hours notice. **Medicaid/CHIP Patients:** MCNA Dental, DentaQuest, and United Healthcare are notified through our automated system if you cancel or no show for your appointment. In order to keep your insurance active, you must follow your insurance company's policy.

____ I authorize the assignment of benefits where applicable.

____ Patients, or Responsible Parties, are responsible for all fees incurred regardless of dental insurance. All copayments and deductibles are due at time of service. If you have insurance that we do not participate with, all payments are due at time of service.

____ I accept full responsibility for any legal or collection agency fee should my account become delinquent.

____ I grant my permission to you, or your assignee, to telephone me at home or at work to discuss matters related to this form.

____ I have received a copy of this office's Notice of Privacy Practices.

I have read the above conditions of treatment and payment and agree to their content.

Patient or Responsible Party (Print) Relationship to Patient

Patient or Responsible Party (Signature) Date