Patient's Name____________________Birth Date__________

Street Address______________________________

City____________________State__________Zip__________

SS#_______________Employer Name____________________

Cell Phone__________Home Phone__________Email____________________

Dental Insurance_______________ID Number_______________Group Number__________

Insured Party's Name____________________Birth Date __________SS#__________

Employer Name____________________General Dentist____________________

Please list medications you are taking below:

Medication Name____________________Why____________________

Medication Name____________________Why____________________

Medication Name____________________Why____________________

Medication Name____________________Why____________________

Medication Name____________________Why____________________

Do You have, or have you had, any of the following

	Yes / No		Yes / No		Yes / No
Joint Replacement.....................		Thyroid or Parathyroid Condition...		Epilepsy or Neurological Problems...............	
Heart Disease............................		Alcohol or Drug Dependency..........		Ulcer or Colitis..	
Heart Murmer............................		Kidney Disorder................................		Shortness of Breath..	
Mitral Valve Prolapse................		Hepatitis........A.........B........C.............		Unusual Swelling Feet/Ankles.......................	
Pacemaker or Artificail Valve...		Venereal Disease..............................		Excessive Bleeding from cut or extraction...	
Rheumatic Feaver......................		HIV Positive or AIDS.........................		Excessive Thirst/Urination............................	
High Blood Pressure..................		Tuberculosis......................................		Fainting or Dizziness......................................	
Blood Disorder...........................		Liver Disease.....................................		Are you Pregnant?......................................	
Blood Transfusion.....................		Organ Transplant.............................		Latex Allergy..	
Malignancies/Cancer................		Diabetes..		Stroke...	
Radiation or Chemotherapy....		Glaucoma..		Sinus Trouble...	

List any Allergies to Medication:______________________________

I authorize treatment and agree to pay all fees charged for such treatment. I agree to pay all charges for myself and all members of my family promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance. I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved with my care. If my account becomes assigned to a collection agency, I agree to pay 25-33 1/3% collection agency fees, court costs, and attorney fees. I understand that accounts with a balance over 60 days will be assed a 1.5% late charge per month on the unpaid monthly balance.

Patient's Signature (guardian if minor)____________________Date__________