

Patient Information: (Please print)

Please complete this entire questionnaire. This information is necessary for your protection and will be considered confidential.

TODAY'S DATE:

Main patient information form with fields for name, address, birthdate, social security, occupation, school, etc.

Person Responsible for Account: (If different from patient)

Form for person responsible for account with fields for name, address, employment, etc.

Dental

Dental history questionnaire with Yes/No checkboxes for general health, dental visits, check-ups, etc.

Medical

Medical history questionnaire with Yes/No checkboxes for physical exam, illnesses, surgeries, etc.

If the Patient is a Child

Child-specific questions with Yes/No checkboxes.

I hereby acknowledge the medical history is correct and complete and will inform of any future changes.

X _____

Allergies or adverse reactions to: Local anesthetics, Penicillin, Codeine, etc.

All Patients: Please read, sign and date.

The undersigned hereby authorize doctor to perform any and all forms of treatment, medication and therapy, (with patients prior consent)

that may be indicated in connection with (Name of Patient) _____ and further authorizes and consents that Doctor choose and emply such assistance as he deems fit. I also understand dental treatment and the use of anesthetic agents embodies a certain risk including needle separation. If you have any questions or concerns please ask. Any balance over 90 days will be charged 9% monthly service charge or a minimum of \$1.00 Any costs of collection will be added to balance due.

Signature: _____ Date: _____

Relationship: _____

Dental Insurance Patients: Please read, sign and date.

I agree to have my signature considered to be "on File" for the purposes of insurance form processing, and to be responsible for payment for any service or portion of service not covered by insurance. In the event of default in payment, patient or party responsible for fees agrees to pay any and all costs of suit, collection and attorney's fees.

I authorize release of necessary information relating to the processing of dental insurance forms. In order for us to process your insurance forms more rapidly and to assist you in getting all the benefits to which you are entitled, please sign and date below.

Signature: _____ Date: _____
("on file")

Dental Insurance Information:

PRIMARY CARRIER

SECONDARY CARRIER

Insured Person's

NAME (Last, First, M.I.)	_____	_____
STREET, PHONE	_____ () _____	_____ () _____
CITY, STATE, ZIP	_____	_____
BIRTHDATE (M/D/Y)	_____	_____
SOCIAL SECURITY #	_____	_____

Employer

STREET, PHONE	_____ () _____	_____ () _____
CITY, STATE, ZIP	_____	_____

Insurance Company

STREET, PHONE	_____ () _____	_____ () _____
CITY, STATE, ZIP	_____	_____
GROUP #	_____	_____
POLICY #	_____	_____
UNION LOCAL #	_____	_____
ANNUAL DEDUCTIBLE	_____	_____
ANNUAL MAXIMUM	_____	_____
EFFECTIVE DATE OF INS.	_____	_____