PATIENT INFORMATION: Please print TODAY'S DATE: _____

NAME (Last, First, MI)**:**	**BIRTHDATE** (MM/DD/YYYY)**:**
ADDRESS:	**CITY:**
STATE:	**ZIP:**
CHECK APPROPRIATE BOX: ◯ **Minor** ◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Widowed** ◯ **Separated** ◯ **Other Dependant (explain)**_____ **Name of Guardian or Spouse:**_____ **Patient's Relationship to above:**_____ **APPOINTMENT REMINDERS:** Office will do a courtesy appt reminder but we simply cannot control changed or non-working phones. The patient is responsible for their appt and must call office > 24 hrs (long appts 48 hr) prior to their appt, during business hours, to cancel/change to avoid a fee. **I understand and acknowledge office appointment policy: Your Initials:** _____	**CELL PHONE:**_____ **May the Office communicate with you via Text?** ◯ **Yes** ◯ **No** **HOME PHONE:**_____ **EMAIL:**_____ **May the Office communicate with you Email?** ◯ **Yes** ◯ **No** **Employer Name:** **Work Phone:**_____ **Emergency Contact Name:** **Emergency Contact Phone:**_____
Special Notes or Accommodations for Patient:	

RESPONSIBLE PARTY (Person Financially Responsible for Account): **Patient is Responsible** ◯

NAME (Last, First, MI):	**SSN:**
ADDRESS:	**CITY:**
STATE:	**ZIP:**
Patient Relationship to Responsible Party: **Is Responsible Party a Patient With Us?** ◯**Yes** ◯**No**	**HOME PHONE:** **CELL PHONE:** **EMAIL:**

DENTAL INSURANCE DETAILS* **Policyholder/Subscriber is Same as Patient** ◯

*Note this applies only to Dental (**not Medical**) Insurance. Promptly advise office on any changes to contact or insurance information.

Subscriber (Last, First, MI)**:**	**Subscr. Birthdate** (MM/DD/YYYY):
Subscr. SSN: _____ **Patient Relationship to Subscr.:**_____	**Subscr. Home Address:** **City** **State** **Zip**
PRIMARY DENTAL INSURANCE:_____ **Member. Id:**_____ **Group #:**_____	**Insurance Claims Address:** **City** **State** **Zip**
Do you have Secondary Dental Insurance? ◯**Yes** ◯**No** Discuss with Office.	**Note:** As of Jan 2016, Our office will no longer process **secondary** dental insurance. Co-pays will be based on primary dental insurance.

MEDICAL HISTORY DETAILS Please inform Dentist of any changes to medical history **PRIOR** to treatment.

SPECIAL ALERTS

Epilepsy/Convulsions ○**Yes** ○**No**	Pregnant/Nursing ○**Yes** ○**No**	Diabetes ○**Yes** ○**No**
Vertigo ○**Yes** ○**No**	Joint Rep/Artificial Joints ○**Yes** ○**No**	Heart Disease/Attack ○**Yes** ○**No**
Pacemaker ○**Yes** ○**No**	Use Blood Thinner ○**Yes** ○**No**	Stroke ○**Yes** ○**No**
Heart Murmur ○**Yes** ○**No**	Liver/Kidney Disease ○**Yes** ○**No**	High Blood Pressure ○**Yes** ○**No**
Tuberculosis ○**Yes** ○**No**	Asthma/Breathing Prob. ○**Yes** ○**No**	Cancer ○**Yes** ○**No**
Hepatitis ○**Yes** ○**No**	Stomach Trouble/Ulcers ○**Yes** ○**No**	Hist. of Rheumatic Fever ○**Yes** ○**No**
Use Alcohol ○**Yes** ○**No**	Smoke / Use Tobacco ○**Yes** ○**No**	Use Recreational Drugs ○**Yes** ○**No**

Do you use **prescription/non-prescription medications.** ○**Yes** ○**No** If Yes, **provide list** or ask staff for addendum.

Pharmacy _____

KNOWN ALLERGIES. No known allergies ○

Local Anesthetics (e.g., Novocaine) ○**Yes** ○**No**	Penicillin or other antibiotic ○**Yes** ○**No**	Barbiturates / Sleeping Pills ○**Yes** ○**No**
Sulfa Drugs ○**Yes** ○**No**	Sedatives ○**Yes** ○**No**	Iodine ○**Yes** ○**No**
Aspirin ○**Yes** ○**No**	Tylenol ○**Yes** ○**No**	Latex Rubber ○**Yes** ○**No**
Codeine ○**Yes** ○**No**	Other - Please Detail:	

Other Medical History and Conditions _____

DENTIST NOTES:	**Dentist Signature**_____**Date**_____

Terms

Our office submits dental insurance claims to your carrier as a courtesy and we provide a best estimate for your (patient) portion of treatment cost. However, please be aware that the patient's actual insurance benefits may be higher or lower. While our office will make a best faith effort in assisting the patient with successful filing and processing of insurance claims, the patient is responsible for payment in full to include any and all charges for dental services and materials not paid for by their dental plan. The patient is responsible for ensuring we are an in-network provider under their insurance plan. Full payment (or estimated insurance co-payment) is expected at the time of dental services, unless other arrangements have been approved by the office prior to treatment start. For comprehensive treatments requiring multiple office visits, our office requires payment in full at the start of treatment, unless other arrangements have been approved in writing. **Appointment cancellations under 24 hours notice** (**48 hours for long appts**) (required during business hours), are subject to a minimum cancellation fee of $35 with an additional $35 assessed per half hour of appointment length. Failure to pay balances in a timely fashion, frequent appointment cancellations or broken appointments, lack of regularity or follow-through with Doctor advice, or any disregard for office staff or policies, may result in dismissal from practice. Delinquent accounts will be turned over to a collection agency and include collection expenses.

By signing below, I certify that I have accurately provided details on my medical history and conditions to the best of my knowledge and understand that providing incorrect information can be dangerous to my health. I also certify that I understand and accept the Terms as stated on this form.

Patient (or Guardian) Signature _____ Date _____