# WELCOME

## one ABOUT YOU

Today's Date: ____/____/____ File #:____

**Patient Name:** _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate:____/____/____ Age:_____ SS#: _____

Mailing Address:_____

_____
CITY STATE ZIP

Home Phone #: (_____)_____

Work Phone #: (_____)_____ Ext:_____

Cell Phone #: (_____) _____

E-mail Address:_____

Referred By: _____

**Employer:**_____How Long?_____

Employer's Address:_____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

## two INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Relation:_____Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Relation:_____Date of Birth: ____/____/____

Insured's Employer: _____

## three ACCOUNT INFO

**Person ultimately responsible for account**

Name:_____

Relation: _____

Billing Address:_____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____)_____

**Payment method:** ❑ Cash ❑ Check

_____ ____/____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

## four IN EVENT OF EMERGENCY

Whom should we contact: _____

Home Phone # _____

Work Phone # _____

Cell Phone # _____

Who is your Medical Doctor? _____

Doctor's Phone # _____

Doctor's Fax # _____

# MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

. Prosthetic cardiac valve Y N

. Previous infective endocarditis Y N

. Congenital heart disease (CHD)* Y N

. Unrepaired cyanotic CHD, including palliative shunts and conduits Y N

. Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure** Y N

, Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit endothelialization) Y N

. Cardiac transplantation recipients who develop cardiac valvulopathy Y N

Note: (*) Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

(**) Prophylaxis is recommended because endothelialization of prosthetic material occurs within 6 months after the procedure.

"Prevention of Infective Endocarditis - Guidelines from the American Hearth Association, Published April, 2007"

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

| | | | |
|---|---|---|---|
| Y N Heart Attack / Stroke | Y N Thyroid Problems | Y N Cancer/Tumors | Y N Cosmetic Surgery |
| Y N Heart Surg./Pacemaker | Y N Kidney Problems | Y N Shingles | Y N Xray or Cobalt Treatment |
| Y N Heart Murmur | Y N Liver Problems | Y N Hepatitis | Y N Chemotherapy |
| Y N Rheumatic Fever | Y N Respiratory Problems | Y N HIV+/AIDS/ARC | Y N Asthma |
| Y N Mitral Valve Prolapse | Y N Sinus Problems | Y N Arthritis/ Rheumatism | Y N Difficulty Breathing |
| Y N Artificial Valves | Y N Stomach Problems/Ulcers | Y N Artificial Bones/Joints | Y N Diabetes/Hypoglycemia |
| Y N Heart Disease | Y N Psychiatric Problems | Y N Emphysema | Y N Leukemia |
| Y N Congenital Heart Defect | Y N Venereal Disease | Y N Fainting/Seizures/Epilepsy | Y N Anemia |
| Y N Chest Pains | Y N Alcohol/Drug Abuse | Y N Severe/Frequent Headaches | Y N High/Low Blood Pressure |
| Y N Scarlet Fever | Y N Tuberculosis TB | Y N Frequent Neck Pain | Y N Bleeding Problems |
| Y N Nervousness | Y N Jaw Problems TMJ/TMD | Y N Back Problems | Y N Glaucoma |

Please list any other surgeries or medical conditions you have or ever had: _____

_____

MEDICATIONS (Please list) -

_____

_____

_____

_____

ALLERGIES (Please list) -

_____

_____

_____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials Date

Comments

Initials Date

Comments

Initials Date

Comments