

Associates in Family Dentistry

NOTE: The information on this form is necessary for our records. It is considered strictly confidential. Please complete all parts.

NAME _____ AGE _____
Last First Middle
 SPOUSE _____ AGE _____
Last First Middle

SEX: Male Female DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Child Single Married Divorced Widowed

PHONE (Home) _____ (Work) _____ OCCUPATION _____

YOUR PLACE OF EMPLOYMENT _____

YOUR SOCIAL SECURITY NUMBER _____

SPOUSE'S PLACE OF EMPLOYMENT _____

PHYSICIAN _____ PHONE _____

WHO WILL PAY THIS ACCOUNT? _____

METHOD OF PAYMENT? Cash Check MC/Visa # _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____

WHO MAY WE THANK FOR REFERRING YOU? _____

Are you now under the care of a physician? Yes No
 Are you now taking any drugs or medicine? Yes No
 If yes, please specify: _____

Have you been hospitalized in the last 5 years? Yes No
 Are you allergic to ANYTHING (Drugs, Dental anesthetics, penicillin, etc.)? Yes No
 If yes, please specify: _____

Do you get out of breath easily? Yes No
 Do your ankles often swell? Yes No
 Female's only: Are you pregnant? Yes No

Do you have or have you had any of the following? (circle)

| | |
|--------------------------------------|----------------------------|
| Heart murmur | Abnormal bleeding from cut |
| Rheumatic fever | Kidney disease |
| High blood pressure | Tuberculosis |
| Diabetes | Veneral disease |
| Liver disease | Cancer |
| Epilepsy | Thyroid disease |
| Asthma/Bronchitis | Hepatitis |
| Stomach, intestinal trouble | Abnormal heart condition |
| Eye, ear, nose, throat problems | AIDS - HIV Positive |
| Latex allergy | Anxiety/panic disorder |
| Heart attack/bypass surgery | Depression |
| Prosthetic replacement (joint, etc.) | |

| INSURANCE INFORMATION | |
|---|-----------------|
| Policy Holder or Member Name _____ | |
| Address _____ | |
| City/State _____ | |
| Date of Birth _____ | |
| Relationship of Patient to Member _____ | |
| Name of Primary Ins. _____ | |
| Are you covered by secondary ins.? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Soc. Sec. # or ID # _____ | |
| Account or Group # _____ | |
| AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS | |
| I hereby authorize the release of any information acquired during the course of my examination or treatment by Associates in Family Dentistry , and also authorize the payment of insurance benefits directly to same. I agree that I am responsible for the total charges contained herein. My authorizing signature is on file with this provider. | |
| Date _____ | Signature _____ |

Indicate any disease, condition, or problem not listed above that you think we should know about. _____

1. Before treatment can be rendered adequate radiographs of the teeth and mouth must be taken.
2. In this office we use local anesthetic and other methods of pain control to make our patients comfortable while receiving dental treatment.
3. Unless otherwise arranged, payment for professional services is required on the day treatment is rendered.
4. We reserve the right to charge a fee for broken appointments (except in cases of emergency).
5. Patient is responsible for any court costs that may occur.

CONSENT FOR PROCEDURE

This is to certify that I, undersigned, consent to the performing of the dental and oral procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature _____ Date _____