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

Females 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	Venereal 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.? ☐ Yes ☐ 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 _____