PATIENT INFORMATION AND DENTAL HISTORY

DATE_____

PATIENT'S NAME_____DATE OF BIRTH_____

PATIENT'S ADDRESS. STREET: _____

CITY_____ZIP CODE_____

PERSON RESPONSIBLE FOR ACCOUNT_____PATIENT'S PHONE_____

EMPLOYED BY_____BUSINESS PHONE_____

E MAIL ADDRESS_____CELL PHONE_____

PATIENT'S SOCIAL SECURITY NUMBER _____ DENTAL INS._____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

CHIEF ORAL COMPLAINT _____

PREFERENCE ON CONFIRMING APPOINTMENTS: via Phone, Text or Email _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING-INDICATE WITH A (CHECK).

____Teeth sensitive to cold, heat or to sweets?
____Teeth sensitive to pressure or touch?
____Bleeding gums?
____Frequent blisters on lips or in mouth?
____Swelling or lumps in mouth?
____Unpleasant taste?
____Cigarettes, pipe or cigar smoking?
____Chew tobacco?
____Oral Habits, such as Fingernail biting, cheek biting, etc.?
____Clenching or Grinding of Teeth?

Insurance: To avoid any misunderstandings regarding Dental Insurance, we wish our Patients to know That all Professional Services rendered are the obligation of the Patient ultimately. We will prepare Necessary forms or reports to help you obtain your just benefits. We do not render our services on the Basis that Insurance Companies will pay all our fees. Patients are responsible for their accounts and ultimately the payment of fees if any.

APPOINTMENTS: A minimum charge will be made for all failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead, such as, salaries, electric, heat, etc.; which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you alone.
NOTICE; In the event patient's account is turned over to an attorney for collection patient/responsible party is liable for the 33 1/3% Attorney's fee;

PATIENT'S SIGNATURE (PARENT IF MINOR) _____DATE_____