Full Name _____ Date of Birth _____

Social Security # _____Email Address _____

Address _____ City _____ State _____ Zip_____

Telephone: Home _____ Mobile_____

Referred by: _____

Emergency contact: _____ Phone: _____

** We are happy to assist you in understanding and filing your insurance for dental procedures. Please remember your insurance is a contract between you, your employer, and your insurance company; we cannot speak on their behalf. We will gladly act as an advocate, but cannot be responsible for settling any disputed claims or coverage. **We require payment of patient's estimated portion at the time of treatment, including copayments and/or deductibles**. **Our office policy states that you are solely responsible for your bill**.

** **Please take note of our cancellation policy. If we do not receive 48 hours notice**, **any broken appointments will be billed $100 for visits with Doctor and $50 for visits with the Hygienist.**

I have read, understand, and agree to the above listed policies.

Signature _____ Date_____

HEALTH HISTORY

**** Circle "yes" or "no" to indicate if you have had any of the following:**

AIDS/HIV	Y/N	Epilepsy	Y/N	Respiratory Disease	Y/N
Anemia	Y/N	Fainting	Y/N	Shortness of breath	Y/N
Arthritis	Y/N	Sinus trouble	Y/N	Diabetes	Y/N
Artificial Heart valves	Y/N	Headaches	Y/N	Skin Rash	Y/N
Artificial Joints	Y/N	Heart murmur	Y/N	Pace Maker	Y/N
Asthma	Y/N	Heart problems	Y/N	Stroke	Y/N
Back problems	Y/N	Hepatitis Type __	Y/N	Thyroid problem	Y/N
Bleeding abnormally	Y/N	Herpes	Y/N	Cold Sores	Y/N
Blood disease	Y/N	High BP	Y/N	Tuberculosis	Y/N
Cancer	Y/N	Jaundice	Y/N	Chemotherapy	Y/N
Jaw pain	Y/N	Liver disease	Y/N	Low BP	Y/N
Kidney disease	Y/N	Psychiatric care	Y/N	Nervous problems	Y/N

Medications: _____

Allergies (circle): Aspirin Penicillin Sulfa Latex Other: _____