Chart No _____ Date _____

Name _____ E-mail address _____
LAST FIRST M

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

☐male ☐female ☐married ☐single ☐other Birthday_____ SSN_____

Employer _____ Address_____

Whom may we thank for referring you to our office? _____Reason for visit?_____

DENTAL INSURANCE INFORMATION			
DO YOU HAVE DENTAL INSURANCE? ☐YES ☐NO If yes, please complete Information on right	DENTAL INSURANCE NAME	NAME OF PRIMARY SUBSCRIBER	RELATIONSHIP
	EMPLOYER	SOCIAL SECURITY	BIRTHDAY
	SECONDARY INSURANCE NAME (if any)	NAME OF PRIMARY SUBSCRIBER	RELATIONSHIP
	EMPLOYER	SOCIAL SECURITY	BIRTHDAY

PLEASE CHECK IF YOU HAVE OR HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

Check (✓) if you have or have had problems with any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepititis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

1. Have you ever been instructed to take medication prior to dental visit (ANTIBIOTIC PREMED)? ☐Yes ☐No
2. Are you allergic to any of the following medications? ☐PENICILLIN ☐CODEINE ☐ASPIRIN ☐NOVACAINE ☐OTHER_____
3. List any medications you are taking now _____
4. Have you ever tested positive for: ☐HEPATITIS ☐AIDS/HIV ☐VENERAL DISEASE
5. Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No

Date of last dental exam_____ **Name of Previous Dentist**_____ **Location**_____

I understand that payment is required at the time of service unless prior arrangements have been made. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I am aware that I am responsible for any collection and/or legal fees incurred should this account become delinquent. I also authorize the release of any dental information necessary to process this claim.

X _____ _____
Signature of Patient or Responsible Party Date

Today's visit will be paid by: ☐Cash ☐Check ☐VISA/MC/AMEX/DISCOVER
☐I wish to discuss the Dental Office's Financial Option

FOR GENTLE DENTAL USE ONLY

☐HMO _____ ☐PPO_____ ☐DISCOUNT_____ ☐OTHER _____
☐ office will file claim ☐patient will file claim ☐ no claims needed