

PATIENT INFORMATION

Today's Date: _____

Legal Last Name: _____ Legal First Name: _____
Middle Initial _____ Preferred Name/Nickname: _____
Date of Birth: _____ Pronouns: ☐ he/him ☐ she/her ☐ they/them
Address: _____ City/State/Zip: _____
Home Phone #: _____ Cell Phone #: _____
Email: _____ Social Security #: _____
Marital Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed
Patient's Employer: _____ Occupation: _____
In case of emergency, notify: _____ Phone: _____
Whom may we thank for referring you to our office? _____

DENTAL INSURANCE

Primary Dental Insurance ☐ yes ☐ no

If Yes, Company Name: _____ Phone: _____
Subscriber Name: _____ Subscriber Birthdate: _____
Subscriber ID # or SS#: _____ Group Number: _____
Claims Address (Street, City, State, Zip): _____

Secondary Dental Insurance ☐ yes ☐ no

If Yes, Company Name: _____ Phone: _____
Subscriber Name: _____ Subscriber Birthdate: _____
Subscriber ID # or SS#: _____ Group Number: _____

ACCOUNT INFORMATION

Person Financially Responsible for Account: _____ Phone #: _____
Address (Street, City, State, Zip): _____
Patient's Relationship to Person Responsible for Account: _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____
Do you have any drug allergies or have you had an adverse reaction to any medication (including but not limited to: penicillin, dental anesthetics, codeine, erythromycin, sulfa antibiotics)? ☐ NO ☐ YES
If yes, what medication or drug: _____

Do you have any of the following? (Check boxes that apply)

- | | | | | |
|--|--|--|---|--|
| ☐ Heart Disease | ☐ Rheumatic Fever | ☐ Hepatitis | ☐ Circulatory Problems | ☐ General Allergies |
| ☐ Asthma | ☐ Pacemaker | ☐ Excessive Bleeding | ☐ Cancer | ☐ Diabetes |
| ☐ Mitral Valve Prolapse | ☐ AIDS/HIV | ☐ Respiratory Disease | ☐ Epilepsy | ☐ Thyroid Disease |
| ☐ Artificial Heart Valve | ☐ Stroke | ☐ History of bisphosphonates (IV or oral) | | |
| ☐ Premedication Needed for Dental Treatment (if yes, what medication and for what reason:_____) | | | | |

Are there any other conditions not listed above for which you are under the care of a physician?

- ☐ NO ☐ YES- please list conditions here:_____

Please list any medications you are taking at this time:

NAME OF MEDICATION	DOSE	REASON

FEMALES ONLY: Are you pregnant? ☐ NO ☐ YES Are you taking birth control pills? ☐ NO ☐ YES

OFFICE FINANCIAL POLICY (AS OF 07/27/2026)

We accept all insurances as out-of-network providers. **Payment will be due in full at the time of service.** As a courtesy, we are happy to submit claims to your insurance, and **your insurance company will reimburse you directly.** We do our best to estimate what insurance will cover and reimburse you, based on the information provided by them. Please remember this is an estimate, and you are responsible for any remaining balance after insurance has paid their portion. If payment for services already rendered has not been paid in full within 90 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.

Returned Checks will be subject to a fee of \$35.00.

I have read and understand this financial policy.

Patient signature: _____

CANCELLATION POLICY

As a courtesy to all of our patients, we kindly request two business days notice when rescheduling an appointment. We reserve the right to charge a fee for those patients who do not comply with this policy.

I have read and understand this cancellation policy.

Patient signature: _____