ariairvanidds

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date: ____________________

OFFICE USE ONLY:

Patient# ____________________

SS# ____________________

PATIENT INFORMATION

Name: ____________________ Birthdate: __________ Home Phone: __________

Street Address: ____________________ City: __________ State: __________ Zip: __________

Sex: ☐ Male ☐ Female Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Minor ☐ Seperated ☐ Single ☐ Partnered

E-mail: ____________________ Mobile Phone: __________

Employer/School: ____________________ Employer Phone: __________

Employer Address: ____________________ City: __________ State: __________ Zip: __________

Spouse/Partner/Parent's Name: ____________________ Employer: __________ Employer Phone: __________

Whom may we thank for referring you? ____________________

Person to contact in case of emergency: ____________________ Phone: __________

RESPONSIBLE PARTY

Responsible Party Account Name: ____________________ Relation to Patient: __________

Street Address: ____________________ City: __________ State: __________ Zip: __________

Driver's License#: __________ Birthdate: __________ Bank: ____________________

Employer: ____________________ Work Phone: __________

Currently a patient in our office? ☐ YES ☐ NO E-mail: ____________________ Mobile Phone: __________

INSURANCE INFORMATION

Name of Insured: ____________________ Relation to Patient: __________

Birthdate: __________ Social Security#: __________ Date Employed: __________

Employer: ____________________ Employer Phone: __________

Employer Address: ____________________ City: __________ State: __________ Zip: __________

Insurance Company: ____________________ Group#: __________ Union Local#: __________

Insurance Address: ____________________ City: __________ State: __________ Zip: __________

How much is your deductible? __________ How much have you used? __________ Max. Annual Benefit: __________

ADDITIONAL INSURANCE

Name of Insured: ______ Relation to Patient: ______

Birthdate: ______ Social Security#: ______ Date Employed: ______

Employer: ______ Employer Phone: ______

Employer Address: ______ City: ______ State: ______ Zip: ______

Insurance Company: ______ Group#: ______ Union Local#: ______

Insurance Address: ______ City: ______ State: ______ Zip: ______

How much is your deductible? ______ How much have you used? ______ Max. Annual Benefit: ______

DENTAL HISTORY

Reason for today's visit: ______ Date of last dental care: ______

Former Dentist: ______ Date of last dental x-rays: ______

Dentist Address: ______ City: ______ State: ______ Zip: ______

Please check if you have had problems with any of the following: ☐ Bad Breath ☐ Bleeding Gums ☐ Clicking or Popping Jaw

☐ Food collection between the teeth ☐ Grinding Teeth ☐ Periodontal treatment ☐ Loose teeth or broken fillings

☐ Sores or growth in your mouth Sensitivity to any of the following: ☐ Cold ☐ Hot ☐ Sweets ☐ When biting

How often do you floss? ______ How often do you brush? ______

MEDICAL HISTORY

Physician's Name: ______ Date of last visit: ______

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of pentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine): ☐ YES ☐ NO

Have you had any serious illness or operations? ☐ YES ☐ NO If yes, describe: ______

Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, give approximate date: ______

(Women) Are you pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

Please check if you have had any of the following:

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

MEDICAL HISTORY CONTINUED

Please list medications you are currently taking and the correlating diagnosis:

Allergies:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I, or my minor child, ever have a change in health.

I certify that, I and/or my dependent(s), have insurnance coverage with ______________________________ (Insurance Company) and assign directly to all insurnace benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-name dentist may use my health care information and my disclose such information to the above-name insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services This consent will end when the current treatment plan is completed or one year form the date signed below.

Signature of Patient, Guardian or Personal Representative: ______________________________

Please Print Name of Patient, Guardian, or Personal Representative: ______________________________

If Signature not of the Patient, Relation to Patient: ______________________________

Date: ____________________

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED