

## Welcome

## Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

	mation (Confi	aennai)		Patient Number				
Name				Date				
		Birthdate						
Address		City		_ State/ _ Prov		Code		
E-mail	Cell Phone	Marital Status	Single	Married State/	Separated	Divorced	Widowe	
f Student, Name of School/Co	llege	City			.0.0	Full Time		
Patient's or Parent's Employer	Ministration			_ Work Ph	none	Zip/Post.		
Business Address		City		Prov		Code		
Spouse or Parent's Name	use or Parent's Name Employer							
Whom May We Thank for Refe	rring You?							
Person to Contact in Case of E	mergency			Phone_				
Responsible Name of Person Responsible for	<u>#</u>			Relation to Patier				
Address				_Home P	hone			
Driver's License #	BirthdateCe			ll Phone				
Employer		Work Phone		SS# _				
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Over Please

## Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I understand that this examination is going to address my immediate problem or emergency and should not be confirmed as a complete examination with resulting treatment.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by dental or medical care payor.

FINANCE CHARGE. If I don't pay the entire New Balance within 25 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of \$2.00 for a balance under \$134) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account.

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PATIENT'S OR GU	JARDIAN'S SIGNATURE				DAT	re		
Medical In	formation							
Name of Your Phys	e of Your Physician Last Physical			Do You Have, Or Have You Ever Had?			Please Circle	
Are You Taking Any Medications? Please List _		List		Heart Mur	mur		YES	NO
	4.			Fainting S	Spells		YES	NO
·				Heart Cor	ndition		YES	NO
None and the second sec				Malignand	CV		YES	NO
				1770	Blood Pressure		YES	NO
Are You Allergic To Any Medications/Food? Please List				Tuberculo			YES	NO
				Abnormal			YES	NO
Have Vey Been He	anitalizad la Tha Last 5 Vasus 0	M/h. O		Positive H			YES	NO
have you been ho	spitalized In The Last 5 Years?	vvny?	-	Anemia			YES	NO
× .				Radiation	Therany		YES	NO
Dental Info				Diabetes	Пегару		YES	NO
Demai ime	riidion			Venereal I	Dispaso		YES	NO
How Long Has It B	een Since Your Last Dental Vis	it?		Epilepsy/S			YES	NO
What Was Done At That Time?				Hepatitis	SCIZUIC		YES	NO
What was Done At	. mat mine:			Asthma			YES	NO
				Rheumatic	c Fovor		YES	NO
What Is Your Probl	em or Complaint At This Time?				Be Pregnant?		YES	
What is four Frobi	em or complaint At This Time:			wight fou	be riegnant:		IES	NO
ATTENDED TO THE PARTY OF THE PA				Comment	s			
	The second secon			-	*****			
How Long Has It B	een A Problem?		·					241000
Medical Up	odates Dental a	nd Medico	al Histori	es Up	odates			
I have read my M	MEDICAL HISTORY dated		and confir	m that it ade	equately states	past & pres	ent condi	tions.
DATE	EXCEPTIONS	MONES	PATIENTS SIG	NATURE	B.P.		IEWED BY	1
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