

**Welcome to Our Practice** This confidential information will help us prepare for your visit.

**NAME** \_\_\_\_\_  
Mr Mrs Ms Rev Dr

I prefer to be addressed as \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ PO Box \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_

Please provide your cell # for emergency purposes:  
Cell# \_\_\_\_\_

Email: \_\_\_\_\_

**Employer** \_\_\_\_\_

Occupation \_\_\_\_\_ There for \_\_\_ yrs

Who may we thank for referring you to our office?  
\_\_\_\_\_

Other friends or family members seen in our office?  
\_\_\_\_\_  
\_\_\_\_\_

**Spouse's Name** \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Phone# \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_ There for \_\_\_ yrs

**Account Information**

**Name on Account**  Self  Spouse  Other

**Preferred Payment Arrangements** (please check one)

Cash or personal check at time of treatment

Visa, MasterCard or Discover at time of treatment

I wish to establish credit with your office for personalized financial arrangements. I authorize a credit history report.

What brings you in to see us?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What should we know about you in order to work well together?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How has your past dental treatment worked out for you?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK .....**

My current **MEDICAL** health is

excellent     good     poor  
Are you under the care of a physician?     No     Yes

Physician Name \_\_\_\_\_

Office telephone \_\_\_\_\_

List all medications you take (prescription and over counter)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever had the following**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart Attack                                | <input type="checkbox"/> Heart Surgery   | <input type="checkbox"/> Heart Murmur            |
| <input type="checkbox"/> Pacemaker                                   | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Acid Reflux/GERD        |
| <input type="checkbox"/> Scarlet Fever                               | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Kidney Problems         |
| <input type="checkbox"/> Cancer                                      | <input type="checkbox"/> Chemotherapy    | <input type="checkbox"/> Radiation Treatment     |
| <input type="checkbox"/> HIV / Aids                                  | <input type="checkbox"/> Shingles        | <input type="checkbox"/> Artificial Joint        |
| <input type="checkbox"/> Fever Blisters                              | <input type="checkbox"/> Cold Sores      | <input type="checkbox"/> Artificial Valve        |
| <input type="checkbox"/> Stroke                                      | <input type="checkbox"/> Sinus Trouble   | <input type="checkbox"/> Epilepsy / Seizures     |
| <input type="checkbox"/> Diabetes                                    | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Psychiatric Problems    |
| <input type="checkbox"/> Ulcers                                      | <input type="checkbox"/> Colitis         | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> Anemia                                      | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Hemophilia / Bleeding   |
| <input type="checkbox"/> Arthritis                                   | <input type="checkbox"/> Emphysema       | <input type="checkbox"/> Venereal Disease        |
| <input type="checkbox"/> Fainting                                    | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Difficulty Breathing    |
| <input type="checkbox"/> Premedication Required for dental treatment |  |  |
| <input type="checkbox"/> Hospitalized _____                          |  |  |

- High / Low Blood Pressure  
 Blood Transfusion  
 Severe or Frequent Headaches \_\_\_\_\_

**Are you Allergic to or have had difficulty with any of the following substances ....**

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Penicillin        | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Latex             |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Codeine      | <input type="checkbox"/> Dental Anesthetic |
| <input type="checkbox"/> Sulfa             | <input type="checkbox"/> Erythromycin |  |
| <input type="checkbox"/> Other Drugs _____ |                                       |  |

**Do you exercise regularly**     Yes     No  
If YES what do you enjoy doing? \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

*All past due amounts are assessed 2% per month*

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**Dental Insurance Information and Agreement**

As a service to our valued patients WE SUBMIT TO ALL INSURANCE COMPANY PLANS AND FILE ALL INSURANCE CLAIMS ELECTRONICALLY.

**A COPY OF YOUR INSURANCE CARD IS REQUIRED FOR OUR FILES.**

The responsibility of the insurance company is to you and it is important that you insure you are reimbursed properly. Fees for services provided to insured patients are the usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your employer. The percentage of the fee paid may therefore be different than the percentage stated by your insurance company or different than the percentage listed in your benefit booklet. We will do our very best to be certain that you receive all of the benefits due to you from your insurance carrier, if you have questions please contact us at 293-7778.

*I wish to have you file my claims electronically. I have read the above completely and agree to the arrangements stated.*

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**For Women**

- Are you taking birth control pills     No     Yes  
Are you pregnant     No     Yes  
Are you nursing     No     Yes

**Thank you for filling this form out completely. I look forward to serving you! If you have questions regarding this form or any aspect of our dental practice please call.**

Steve Davidson

293-7778 Office  
293-7632 Home

