

WELCOME TO OUR OFFICE

TODAY'S DATE ___/___/___
D M Y

Name: Mr./Mrs./Ms./Dr. _____
(GIVEN NAME) (FAMILY NAME)

Address: _____
(NUMBER) (STREET) (APT.)
(CITY) (POSTAL CODE)

Telephone: Home _____ Business _____ Ext. _____

Date of Birth ___/___/___ Present Age _____ Sex: M F
D M Y (Circle)

Referred By _____

Employer _____ Email: _____

Are you covered by Dental Insurance? No Yes Insurance Co.? _____

Group # _____ Employee ID # _____

Your Physician: Name: _____ Telephone _____

I understand that the total payment of the dental service is my responsibility and not that of the insurance company. (We will be happy to complete any insurance form so that you may be reimbursed by your insurance company.) Unless prior arrangements are made, payment is due when services are rendered.

In Order to provide you with the best possible dental health care we must know the following information, all of which will be kept confidential:

(Circle)

- 1. Have you ever had an unusual reaction to any drug or anesthetic? No Yes
2. Is your physician treating you now? No Yes
3. Are you taking any medicines? No Yes
4. Do you have any allergies? No Yes
5. Have you ever had prolonged bleeding or delayed healing following an injury or dental surgery? No Yes
6. Do you have a cardiac pacemaker or artificial heart valve? No Yes

7. Have you ever had: (Please Circle)

- Rheumatic Fever Heart Problem or Murmur AIDS
High Blood Pressure Hepatitis Kidney Problem
Liver Problem Asthma Diabetes
Spilapsy Cancer Or Tumor Thyroid problem
Blood Disorder Any Other _____

8. Women: Are you pregnant? (If Yes, When due _____) No Yes

9. Is there anything else the dentist should know about your health? No Yes

Permit of Operations

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's) Signature _____