Today's Date _____

Welcome to our office. We will do our best to make your appointments as convenient as possible. If at any time you have questions regarding your treatment, your appointments, or fees, please feel free to ask.

PATIENT INFORMATION:

Name: _____ Date of Birth: _____/_____/_____

Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Cell Phone: _____

Purpose of Visit: _____ SS# _____-____-_____

RESPONSIBLE PARTY'S INFORMATION:

Name: _____ SS# _____-____-_____ Date of Birth: _____/_____/_____

Address: _____
STREET CITY STATE ZIP CODE

Driver's License # _____ Cell Phone: _____

Employer Name: _____ Address: _____

Home Phone: _____ Business Phone: _____

Spouse's Name: _____ SS# _____-____-_____ Date of Birth: _____/_____/_____

Employer Name: _____ Address: _____

Do you have Insurance? If yes, please present information: _____

Who can we thank for referring you to us? _____

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

The name of my physician is _____ Date of last Medical exam _____

Are you now under the care of a physician? _____

If so, what is the condition being treated _____

Do you have or have you had any of the following diseases or problems:

	Yes	No		Yes	No
1. Rheumatic Fever	☐	☐	11. Stomach Ulcers	☐	☐
2. Congenital Heart Lesions	☐	☐	12. Kidney Trouble	☐	☐
3. Heart Trouble, Heart Attack, Stroke	☐	☐	13. Tuberculosis	☐	☐
4. High Blood Pressure	☐	☐	14. Venereal Disease	☐	☐
5. Allergy	☐	☐	15. Sinus Trouble	☐	☐
6. Asthma or Hay Fever	☐	☐	16. Anemia or Blood Disorder	☐	☐
7. Hives or a Skin Rash	☐	☐	17. Tumors or Growths	☐	☐
8. Fainting Spells or Seizures	☐	☐	18. Nervous Condition	☐	☐
9. Diabetes	☐	☐	19. Radiation Therapy	☐	☐
10. Hepatitis, Jaundice or Liver Disease	☐	☐	20. AIDS	☐	☐
			21. Cancer	☐	☐

Do you use Tobacco in any form: snuff _____ cigarettes _____ cigars or pipe _____ chew _____

Are you allergic to:

	Yes	No		Yes	No
1. Local anesthetics	☐	☐	5. Aspirin	☐	☐
2. Penicillin or other antibiotic	☐	☐	6. Iodine	☐	☐
3. Sulfa drugs	☐	☐	7. Codeine	☐	☐
4. Barbiturates, sedative, or sleeping pills	☐	☐	8. Other	☐	☐

Are you taking drugs or medications presently? _____ **If so, what?** _____

_____

Have you ever had any serious trouble associated with any previous dental treatment:

_____

Last visit to a dentist _____

Dentist Name _____ Type of Treatment _____

WOMEN: Are you Pregnant? _____ **How far along?** _____ (OVER)

1. What is most important to you about your teeth (oral health)? (Comfort, appearance, function, freedom from expense, etc.)

_____

_____

_____

2. What do you do currently to keep your mouth healthy? (brush daily, brush and floss daily, use water pic, brush occasionally, none of the above)

_____

_____

_____

3. Who is responsible for payment of professional services rendered?

_____

_____

_____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Dr. Bauer to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the Dentist all payments for dental services rendered.

All accounts 60 days past due will have 1½% interest added to the unpaid balance per month until the account is current. All accounts over 90 days past due will be turned over to IC Systems for collection and a collection fee will be added to the account.

_____

Parent or Patient Signature