Health History and Registration

Thank you for choosing our office for your dental care. In order to help us render the proper services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think we should have. All information is held in strictest confidence. Thank you for your cooperation.

PERSONAL DATA (Please print)

Today's date _____

Please circle: Mr. Mrs. Miss. Ms. Dr.

Name _____ Marital Status _____
Last *First* *Middle*

Home Address _____ City _____ State _____ Zip_____

Date of Birth _____ Sex _____ Height _____ Weight_____

Home Phone _____ Cell Phone _____ SS# _____

Occupation _____ Employer _____

Employer's Address _____ City _____ State____ Zip_____

Work Phone _____ Your Email Address _____

Which daytime phone is most convenient? Home Cell Work

Spouse's Name _____ Spouse's Date of Birth_____

Spouse's Employer _____ Spouse's SS # _____

Employer's Address _____ City_____ State_____ Zip____

Work Phone _____ Cell Phone _____

Who will be financially responsible for your treatment? (If another) _____

Your signature gives us permission to access your credit history through recognized credit bureaus.

Signature _____

Do you prefer long appointments? (1 hour or longer) Yes No

Whom may we thank for referring you to our office? _____

What is the reason for today's appointment? _____

If you authorize the use of your credit card for the payment of outstanding balances, please give the credit card name and number:

Card Name _____Card Number_____

Expiration Date ____/_____ Security Code: _____ Signature _____

DENTAL INSURANCE INFORMATION
Your insurance carrier:

Name _____ Address _____

Group # _____ ID#_____ Effective Date_____

Your spouse's carrier:

Name _____ Address _____

Group # _____ ID #_____ Effective Date_____

Please list all other family members covered

Full Name/Relationship	Date of Birth	Sex	If over 18, name of college
_____	_____	_____	_____
_____	_____	_____	_____

All insurance forms are computer-processed in our office. Your carrier requires the following signatures to be on file. I (we) authorize realease of any information reative to dental claims. I (we) understand that I (we) am (are) responsible for all costs of dental treatment; and, I (we) hereby authorize payment directly to the provider dentist of the group insurance benefits otherwise payable to me (us).

_____ _____ _____

Your signature *Date* *Spouse's Signature*

It is the policy of this office to accept benefits directly from your carrier(s). However, all deductibles and co-payments are to be paid by you AT THE TIME OF TREATMENT; ARRANGEMENTS FOR EXTENDED PAYMENTS MUST BE MADE IN ADVANCE OF THE START OF EXTENSIVE TREATMENTS.

A written estimate will be prepared following your complete examination and consultation. Your out-of-pocket expenses will be estimated at that time.