*Welcome to our office!*

**The Healthy Smile**

Today's date_____

**Patient Name** _____

Address_____

City _____ Zip _____ Phone _____

Occupation_____

**Employer**_____

Address_____

City _____ Zip_____ Phone_____

Date of Birth _____

Marital Status _____

Social Security Number _____

MasterCard Number _____

VISA Number _____

**Spouse's Name**_____

Address_____

City _____ Zip_____ Phone_____

Occupation _____

Employer _____

Address_____

City_____ Zip _____ Phone_____

Date of Birth_____ Social Security Number _____

**Dental Insurance Company (Primary)**_____

Address_____

City_____ Zip _____ Phone _____

Subscriber name _____ Contract#_____ Group#_____

Dental Insurance Company (Secondary) _____

Address _____

City _____ Zip _____ Phone_____

Subscriber name_____ Contract# _____ Group#_____

What is the primary purpose of your visit? (check-up, pain, etc.) _____

Who referred you to our office?_____

Charges for dental services, including insurance co-pays and deductibles, are due and payable at the time services are rendered. Dental insurance is an agreement **between you and your insurance company;** you are responsible for payment of your bill regardless of the amount covered by your insurance. We are not responsible for broken promises by them or any misunderstandings between you, your insurance company and/or your employer.

Accounts which are 60 days past due from the date of treatment will be charged a monthly service charge of 1.75%. An additional processing fee of $75.00 will be charged if an account is turned over to a collection agency or attorney.

Any broken appointments are subject to a $50 fee

My payments will be made by: ☐Cash ☐VISA or MC

☐Check ☐Outside Financing

I authorize you to use my credit card to pay any outstanding balances or charge monthly amounts if this is acceptable to this office.

**I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS CONCERNING PAYMENTS AND WILL COMPLY WITH THIS POLICY.**

**I SPEAK AND READ ENGLISH OR THIS FORM HAS BEEN EXPLAINED TO ME.**

_____

Patient's Signature Date

# HEALTH HISTORY

Please indicate if you have had any of the following conditions:

| | Yes | No |
|---|---|---|
| Heart Problems | …… | …….. |
| Rheumatic fever | …… | …….. |
| Abnormal blood pressure | …… | …….. |
| Ulcers | …… | …….. |
| Diabetes | …… | …….. |
| Epilepsy | …… | …….. |
| Anemia | …… | …….. |
| Asthma or hay fever | …… | …….. |
| Hepatitis | …… | …….. |
| Stroke | …… | …….. |
| Bleeding problems | …… | …….. |
| Nervous or mental problems | …… | …….. |

Are you allergic to any drugs or medications? _____ If so, please specify _____

_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries, pregnancy, or any other information we should be aware of:

_____

_____

_____

_____

_____

_____

_____

Physician's name and phone _____

_____

Patient's signature Date