Patient's History & Health Information

Patient Name_____
Height_____ Weight_____ Hair color_____ Eye Color_____
Date of Birth_____ Single_____ Married_____ Separated_____ Divorced _____
If Minor Parents Name_____
Address_____
City_____ State_____ Zip _____
Home Phone_____ Business Phone_____
Cell Phone_____ E-Mail_____
Employed by_____
Address_____
Present Position_____
Person Responsible for Account_____
Dental Insurance_____
Social Security #_____ Drivers License #_____
Payment will be made by Cash_____ Check_____ Credit Card_____
Referred By_____
Name of Family Physician_____
Date of Last Dental visit_____

Spouse Information
Spouse_____
Employed by_____
Present Position_____
Address_____
Business Phone_____
Social Security #_____
Dental Insurance_____

In case of Emergency, Contact:

Name Nearest Relative (not living with you) _____
Address_____ Phone_____

I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly understanding between doctor and patient.

Authorization:

I/we grant authority to the Dentist to perform procedures and treatments, including administration of medicine, local anesthetics, and extractions, along with other surgical and dental procedures that may be necessary. I /we agree to pay collection costs and/or a reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit.

Patient's Signature_____ Date_____

(Parent if minor)