Date: ____________________

Patient Name:	**SSN:**	**Home Phone:**
Home Address:	**City/State/Zip:**	**Birthdate:**

Primary Insurance Company: ____________________ **Group #:**_____________ **Subscriber:** _______________________

Secondary Insurance Company: __________________ **Group #:**_____________ **Subscriber:**_______________________

Whom May We Thank For The Referral?

☐ Patient Name: _______________________ ☐ Walk-in

☐ Insurance ☐ Google/Advertisement

I consider my health to be*: (please check one)*: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you had any of the following? *Please circle Y for yes or N for No*

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congential Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis/Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Seizures/Epilepsy
14. Y N Ulcers
15. Y N Implants/Artificial Joints
16. Y N Liver disease
17. Y N Jaundice
18. Y N I usually take an antibiotic prior to dental treatment
19. Y N I have had a major surgery: Year____ Type of operation:________________
20. Y N I smoke or use tobacco. How much per day? _______ How many years? _______
21. Y N Jaundice
22. Y N Hepatitis Type _____
23. Y N Diabetes
24. Y N Herpes
25. Y N Arthritis
26. Y N Sexually Transmitted/Venereal Disease
27. Y N Kidney Disease
28. Y N Cancer/Chemotherapy
29. Y N Radiation Therapy
30. Y N History of Drug Addiction
31. Y N AIDS
32. Y N Immune Suppressed Disorder
33. Y N Hearing Loss
34. Y N Vertigo/Fainting Spells
35. Y N History of Emotional/Nervous Disorders

WOMEN:

36. Y N Are you taking birth control medication?
37. Y N Are you or could you be pregnant or nursing?

38. Y N Do you have any other medical problems or medical history NOT listed on this form? _________________

Are you allergic to any of the following? *Please circle Y for yes or N for no*

39. Y N Aspirin
40. Y N Ibuprofen
41. Y N Sulfa Drugs/Sulfites/Sulfides
42. Y N Penicillin
43. Y N Codeine
44. Y N Latex, Metals, Plastics
45. Y N Local Anesthetics (Novocaine)
46. Y N Other medications? – Which ones? _____________

Please list all medications you are currently taking:

Medicine: ______________________ Condition: ___________________
Medicine: ______________________ Condition: ___________________
Medicine: ______________________ Condition: ___________________
Medicine: ______________________ Condition: ___________________

Physician's Name: ______________________________________ Phone: _________________________

In the event of an emergency, please contact:

Name: ______________________________ Relationship: ________________ Phone: _______________________

OFFICE POLICY REGARDING YOUR INSURANCE: Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to Welleby Family Dental at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full after (45) days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility

____ ______________________________________

Print Name *Signature/Date*