WELCOME

Today's Date __/__/___

Please fill out this form completely; front and back. The better we communicate, the better we can care for you.

Patient Information

First Name: _____ M.I. _____ Last Name: _____

Birthdate: __/__/____ Social Security # _____ Email: _____

Home Address: _____ City/State/Zip: _____

Home#_____ Work #_____ext._____ Cell#_____

Employment Information

Place of Employment: _____

Employer's Address: _____ Phone # _____l_____

Spouse Information

His/Her Name: _____ SS# _____ Birthdate: ___/___/_____

Employer: _____ Work # _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone # _____

If Patient is a Dependent

Is he/she a full time student? Yes ☐ No ☐

Name and City of School: _____

Father's Name: _____ Employer: _____

Father's Work # _____ ext: _____

Mother's Name: _____ Employer: _____

Mother's Work # _____ ext: _____

Person Responsible for Account

Name: _____

Billing Address_____

_____

Home#: _____ Cell # _____

Work#: _____ ext._____

Birthdate: __/___/____ SS# _____

Ins. Co. Name: _____

Claims Address: _____

_____

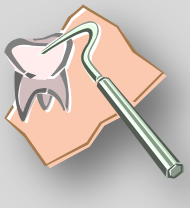
Ph#: _____

Group#_____

Subscriber's Name: _____

Birthdate: ___/___/____

SS#:_____



Patient Medical History

Please check <u>ALL</u> the following medical conditions or problems that you currently have or have had in the past.

- ☐ Artificial Bones/Joints/Valves
- ☐ High/ Low Blood Pressure
- ☐ Arthritis
- ☐ HIV+/AIDS
- ☐ Blood Transfusion
- ☐ Kidney Problems
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Severe Frequent Headaches
- ☐ Sickle Cell Disease/Traits
- ☐ Sinus Problems
- ☐ Venereal Disease
- ☐ Hepatitis
- ☐ Vertigo
- ☐ Cancer Chemo Therapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug/Alcohol Abuse
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Epilepsy/Seizures/Fainting
- ☐ Fever Blisters/Herpes
- ☐ Heart Attack/Stroke
- ☐ Heart Murmur
- ☐ Heart Surgery/Pacemaker
- ☐ Hemophilia/Abnormal Bleed
- ☐ Hospitalized for any reason within the last 2 years

Are you allergic to any of the following? (Please Check)

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry/Metals
- ☐ Penicillin
- ☐ Other _____

Do you require antibiotics before dental treatment? Yes ☐ No ☐

Are you currently under the care of a physician? Yes ☐ No ☐

Physician's Name _____

Phone #_____

Are you taking any prescription/over the counter drugs? Yes ☐ No ☐

Please List:

_____ _____

_____ _____

Do you smoke or use tobacco in any other form? Yes ☐ No ☐

<u>For Women</u>

Are you currently taking birth control pills? Yes ☐ No ☐

Are you Pregnant? Yes ☐ No ☐ Week#____

Are you nursing? Yes ☐ No ☐

<u>For those patients with insurance coverage:</u>

I agree to assign to my doctor all dental insurance payments for treatment given to me or a member of my family for whom I am responsible.

I also agree to pay any balance that is not covered by my insurance carrier. I understand that I am responsible for my account, and that the insurance company is responsible to me and not my healthcare provider.

If my insurance carrier pays benefits directly to me, I agree that I will pay my doctor all payments due for services. I

<u>For those patients who do not have insurance coverage:</u>

If I do not have dental insurance coverage, I understand that I am financially responsible for all bills incurred during my treatment.

<u>Authorization for release of information:</u>

I authorize Dr. David G. Slyby to furnish any professional information necessary for the completion of my insurance claim. Dr. Slyby is hereby released from any legal liability that may arise from the release of the information requested.

If payment has not been received within 30 days from the date of statement a monthly charge of 1 ½% (which is an annual rate of 18%) of the balance due or a charge of $5.00 per statement, whichever is greater, will be added to the amount of your account balance.

I further agree that in the event that the account is not paid in accordance with the office policy, I agree to pay collection costs and reasonable attorney fees if the account is placed in the hands of a collection agency or attorney.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature ***Date***

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions, please ask us. We are more than happy to help!