

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us—we will be happy to help.

1

Personal Information

Name _____ Date _____
Birthdate _____ Soc. Sec. # _____
Wishes to be called _____
 Male Female Minor Single Married Divorced Widowed Separated
Address _____
City, State, Zip _____
Employer _____ Occupation _____
Referred by _____

2

Responsible Party

Who is responsible for the account?
Name _____
Relationship to patient _____ Birthdate _____
Soc. Sec. # _____ Driver's License # _____
Address _____
City, State, Zip _____
Employer _____ Occupation _____
Work Phone _____ Ext. # _____
Home Phone _____ Cell Phone _____

3

Telephone

Home Phone _____ Cell Phone _____
Work Phone _____ Ext. # _____ E-Mail Address _____
Where do you prefer to receive calls? Home Work Cell
When is the best time to reach you? Time _____ Days _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____ Work # _____ Home # _____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
Soc. Sec. # _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. Annual benefit _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
Soc. Sec. # _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. Annual benefit _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent if minor

_____ Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment in full at each appointment.

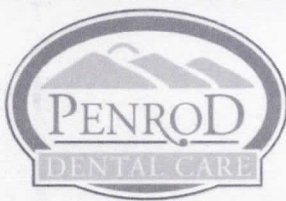
_____ Cash
_____ Personal Check
_____ Credit Card ___ Visa ___ MC

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask—we are always happy to help.



Health History

Name _____ Date _____

Have you been under the care of a medical doctor during the past two years..... Yes No

If yes for what? _____

Physician's name _____ Phone _____

Have you taken any medication or drugs in the past two years?..... Yes No

Are you taking any medication, drugs or pills now?..... Yes No

If yes, please list name(s) and dosage(s) _____

Are you aware of having any allergic or adverse reaction to any medication or substance? Yes No

If yes, please list: _____

Have you been a patient in the hospital during the past five years? Yes No

Indicate which of the following you have had or have at present. (Please circle YES or NO)

Heart (Disease, Attack)	Y / N	Diabetes	Y / N	HIV/AIDS	Y / N
Chest Pain	Y / N	Thyroid Problems	Y / N	Cold Sores/Fever	
Congenital Heart Disease	Y / N	Glaucoma	Y / N	Blisters	Y / N
Heart Murmur	Y / N	Emphysema	Y / N	Bruise Easily	Y / N
Mitral Valve Prolapse	Y / N	Tuberculosis	Y / N	Liver Disease	Y / N
Artificial Heart Valve	Y / N	Asthma	Y / N	Kidney Trouble	Y / N
Heart Pacemaker	Y / N	Allergies or Hives	Y / N	Neurological Disorders	Y / N
Rheumatic Fever	Y / N	Hay fever	Y / N	Epilepsy/Seizures	Y / N
High Blood Pressure	Y / N	Latex Sensitivity	Y / N	Fainting/Dizzy Spells	Y / N
Arthritis/Rheumatism	Y / N	Cancer (Tumors)	Y / N	Nervous/Anxious	Y / N
Cortisone Medicine	Y / N	Chemotherapy	Y / N	Phen-Fen Use	Y / N
Artificial Joints (Hip, Knee, etc.)	Y / N	Radiation Therapy	Y / N		
Ulcers	Y / N	Hepatitis (A, B, or C)	Y / N		

Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list: _____

Do you smoke?.....Yes No If yes, how much? _____

Do you take Tagamet or antacids?..... Yes No

Do you take herbal supplements/medications?.....Yes No If yes, which ones? _____

WOMEN- Are you pregnant?...Yes No (__ mos.) Nursing?...Yes No Birth Control Pills?... Yes No

Are you happy with the appearance of your teeth?..... Yes No

If no, what would you like to change? _____

Any problems or concerns with your oral health (bleeding gums, sensitivity, etc.).....Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient or Parent/Guardian Signature

Date

History Review

Doctor Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

and

DENTAL MATERIALS FACT SHEET

****You May Refuse to Sign This Acknowledgement****

I, _____, have received from Carey L. Penrod, DDS a copy of their Notice of Privacy Practices as well as a copy of the Dental Materials Fact Sheet dated May 2004.

Patient Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)