Welcome

Patient Information

Date_____ Home Phone_____ Cell Phone_____

Name_____ Soc. Sec. # _____
Last Name First Name Initial
CDL # _____

Address _____ Email:_____

City_____ State_____ Zip _____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Person responsible for account_____ Business Name _____

Address_____ Business Phone _____

Whom may we thank for referring you?_____

In case of emergency who, not living with you, should be notified?_____ Phone _____

Primary Insurance

Name of Insured Subscriber _____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec. # _____

Address (if different from patient's)_____ Phone_____

City_____ State_____ Zip _____

Person Employed by_____

Business Address_____ Business Phone _____

Insurance Company_____ Address _____

Union #_____ Group #_____ Insurance Ph # _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No Soc. Sec. # _____

Secondary Subscriber Name_____ Relation to Patient_____ Birthdate _____

Address (if different from patient's)_____ Phone_____

City_____ State_____ Zip _____

Subscriber Employed by_____ Business Phone _____

Insurance Company_____ Address _____

Union #_____ Group #_____ Insurance Ph # _____

Authorization for a Minor Child

I authorize the Dental Staff to perform the necessary dental services my child may need. I also authorize the Dentist to release all information necessary to secure payment of benefits. 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 behalf of my dependents.

Signature of Parent or Guardian_____ Date _____

Please Complete Both Sides

Dental History

Reason for Today's Visit _____

Former Dentist _____

Address _____ Phone _____

Date of last dental care _____ Date of last dental X-rays _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you ever taken FenPhen? ☐ Yes ☐ No

Check (✓) if you have had problems with any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Cortisone Treatments	☐	☐	Hepatitis	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cough up Blood	☐	☐	HIV Positive	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Skin Rash
☐	☐	Artificial Joints	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Fainting	☐	☐	Latex Allergy	☐	☐	Swelling of Feet or Ankles
☐	☐	Back Problems	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Blood Disease	☐	☐	Headaches	☐	☐	Mitral Valve Prolapse	☐	☐	Tobacco Habit
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Nervous Problems	☐	☐	Tonsillitis
☐	☐	Chemical Dependency	☐	☐	Heart Problems	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemotherapy			Describe _____	☐	☐	Pre-Medicate	☐	☐	Ulcer
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Psychiatric Care	☐	☐	Venereal Disease
						☐	☐	Radiation Treatment			
						☐	☐	Respiratory Disease			

MEDICATIONS
List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

Authorization

I to authorize and hereby request my insurance company to pay directly to Foothill Dental Practice, insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Foothill Dental Practice to release any information including the diagnosis and/or records of any treatment or examination rendered for myself or dependents during the period of each dental care to third party payors and / or other health practitioners.

I understand that my dental insurance carrier may pay less than estimated for the actual bill of services rendered and I will be responsible for ALL fees regardless of insurance coverage. Any balance that exists regardless of outstanding insurance will be subject to finance charges at 1.5% per month or 18% annually. I fully understand that Foothill Dental Practice submits dental claims on my behalf as courtesy and any time limitations set by my insurance carrier are my responsibility. I agree to pay all of collections, including, but not limited to, reasonable attorney's fees.

I understand that Foothill Dental Practice reserves the right to charge $50.00 for appointments canceled or broken without a 48 hour advance notice.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.