VILLAGE DENTAL

AUBURN, ALABAMA

Welcome! Please take a few minutes to fill out this form front and back. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____

Name (Last)_____(First)_____(MI)_____Preferred Name _____

Sex __M__F Age _____ Birthdate_____Social Security No._____

Address _____

City _____ State_____ Zip _____

Home Phone_____ Cell_____ Preferred # to call during the day _____

Email Address _____Marital Status _____

Are you a full time student? Yes No If so, where? _____

Employed by _____Who may we thank for referring you to our office?_____

Spouses Name_____Employed by_____ Phone_____

In case of emergency, who should be notified? _____ Phone _____

Responsible Party Information

(If different from patient)

Name_(Last)_____(First)_____(MI)_____Marital Status_____

Relation to the Patient _____ Birthdate _____ Soc. Sec. No. _____

Address _____City_____State_____Zip_____

Home Phone_____Cell Phone_____Drivers License #_____

Employed by_____Work Phone_____

Dental Insurance

Is the patient covered by dental insurance?__Yes __No

If yes, we would like to make a copy of your insurance card.

Subscriber's Name (Last)_____ (First)_____(MI)_____

Relation to the Patient _____ Birthdate _____ Soc. Sec. No. _____

Address (if different from patient) _____

City _____ State_____Zip _____ Phone _____

Employed By _____ Contract #: _____

Insurance Company _____ Group # _____ Insurance Co. Phone _____

Names of other dependents covered under this plan _____

Additional Dental Insurance

Is the patient covered by 2nd insurance? __Yes __No

If yes, we would like to make a copy of your insurance card.

Subscriber's Name (Last)_____(First)_____(MI)_____

Relation to the Patient _____ Birthdate _____ Soc. Sec. No. _____

Dental History

Reason for Today's Visit_____

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

__Bad breath
__Bleeding gums
__Clicking or popping jaw
__Food collection between teeth
__TMJ Problems
__Grinding teeth
__Loose teeth or broken fillings
__Periodontal treatment
__Sensitivity to cold
__Missing Teeth
__Sensitivity to hot
__Sensitivity to sweets
__Sensitivity to when biting
__Sensitivity or growths in your mouth
__Stained or discolored teeth

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

Former Dentist_____

Address _____

City_____ State_____ Zip_____Phone _____

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

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? __Yes __No If yes, describe _____

_____

Are you allergic to latex? __Yes __No Have you ever had a reaction to jewelry or metals? Yes No

(Women) Are you pregnant? __Yes __No If yes, approximate due date _____

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

__Aids
__Anemia
__Arthritis, Rheumatism
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Back Problems
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cortisone Treatment
__Cough, Persistent
__Cough Up Blood
__Diabetes
__Epilepsy
__Fainting
__Glaucoma
__Headaches
__Heart Murmur
__Heart Problems
__Describe _____
__Hemophilia
__Hepatitis
__High Blood Pressure
__HIV Positive
__Jaw Pain
__Kidney Disease
__Liver Disease
__Mitral Valve Prolapse
__Nervous Problems
__Pacemaker
__Psychiatric Care
__Radiation Treatment
__Respiratory Disease
__Scarlet Fever
__Sensitivity to hot
__Sexually Transmitted Disease
__Shortness of Breath
__Skin Rash
__Stroke
__Feet or Ankle Swelling
__Thyroid Problems
__Tobacco Habit
__Tonsillitis
__Tuberculosis
__Ulcer

Please describe a condition if not listed above:_____

Do you premedicate prior to your dental visits? __Yes __No

If so what medication do you take?_____

MEDICATIONS (list any medications you are currently taking including OTC):

_____

_____

ALLERGIES

_____

_____

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information to secure the payment of benefits. I give Village Dental Care authorization to contact me at any/all of the phone numbers (including the cell #) for the purpose of treatment, insurance or payment.

I understand that I am financially responsible for all charges whether or not paid by insurance. Uncollected balances are subject to finance charges, collection fees, and any additional costs related to the collection process. If a check is returned, there will be a returned check fee assessed for a minimum of $30.00.

Signature _____ Date _____

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