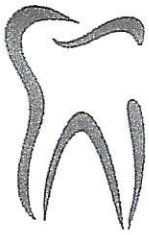

Patient Information

Name_____ Birthday_____ SS#_____
Last First M.I. Nickname

Address_____
Street City State Zip Code

Home Phone_____ Work Phone_____ Cell Phone_____

Email _____ Pharmacy (Name & Number)_____

Marital Status_____ Spouse's Name_____ Whom do we thank for referring you?_____

Responsible Party Information (If other than yourself)

Name_____ Birthday_____ SS#_____
Last First M.I. Nickname

Home Phone_____ Work Phone_____ Cell Phone_____

Spouse's Name_____ Home Phone_____ Work Phone_____

Dental Insurance Information

Policy Holder Name_____ Birthday_____ SS#_____
Last First M.I.

ID No._____ Group No._____ Effect. Date of Ins._____

Ins. CO._____ Address_____
Street City State Zip Code

Employer_____ Address_____
Street City State Zip Code

Do You Have Dual Coverage ( ) Yes ( ) No If Yes, Complete the Following:

Policy Holder Name_____ Birthday_____ SS#_____
Last First M.I.

ID No._____ Group No._____ Effect. Date of Ins._____

Ins. CO._____ Address_____
Street City State Zip Code

Employer_____ Address_____
Street City State Zip Code

Emergency Notification Information

Name_____ Address_____ Phone No._____
Street City State Zip Code

I will inform your office of any changes in my Insurance Coverage

_____ _____
Signature of Patient or Guardian **Date**

Medical History

Name_____ Date_____ General State of Health: Good (__) Fair (__) Poor (__)

Name/Address/Number of Physician_____

Have you been under a physician's care during the past two years? _____

Have you been treated in the hospital during the past three years? _____

Have you had any **Major Surgery?** _____ What/ When_____

Do you or Have you been told to Premedicate before appointments?_____ **Do you take Blood Thinners?**_____

If Female: Are you pregnant? _____ Nursing? _____ On Birth Control?_____

Do you or have you had any of the following?

Yes / No		Yes / No	
( ) ( )	Aids / HIV+	( ) ( )	High Blood Pressure
( ) ( )	Arthritis	( ) ( )	Irregular Heart Beat
( ) ( )	Artificial Heart Valves	( ) ( )	Kidney Problems
( ) ( )	Artificial Joints	( ) ( )	Liver Disease
( ) ( )	Asthma	( ) ( )	Mitral Valve Prolapse
( ) ( )	Bruise / Bleed Easy	( ) ( )	Nervousness / Anxious
( ) ( )	Cancer	( ) ( )	Organ Transplant
( ) ( )	Chemotherapy	( ) ( )	Pacemaker
( ) ( )	Chest Pain / Angina	( ) ( )	Persistent Cough
( ) ( )	Congenital Heart Lesions	( ) ( )	Pneumonia
( ) ( )	Diabetes	( ) ( )	Radiation Fever
( ) ( )	Dry Mouth	( ) ( )	Rheumatic Fever
( ) ( )	Emphysema / Bronchitis	( ) ( )	Sickle Cell Anemia
( ) ( )	Epilepsy / Seizures	( ) ( )	Sinus Problems
( ) ( )	Fainting / Dizziness	( ) ( )	Stroke
( ) ( )	Fibromyalgia	( ) ( )	Thyroid Disease
( ) ( )	Heart Problem / Murmur	( ) ( )	Tobacco Use
( ) ( )	Heart Surgery	( ) ( )	Tuberculosis / PPD+
( ) ( )	Hepatitis A, B, C, D, E	( ) ( )	Venereal Disease

Do you have any Condition, Disease, or Problem not listed above?

_____

_____

_____

Do you have any medication allergies? If yes, please specify

Yes / No		Yes / No	
( ) ( )	Antibiotics (Erythromycin/Tetracycline/Penicillin/Flagyl)	( ) ( )	Dental Anesthetics
( ) ( )	Aspirin / Acetaminophen / Ibuprofen	( ) ( )	Latex
( ) ( )	Codeine	( ) ( )	Sulfa

Any not listed _____

Please list all medications you are taking, including over the counter drugs and herbs_____

_____

_____

_____

Office Financial Policy

It is our continued commitment to provide the highest quality of dental care available to all of our patients, and to have those services comfortably affordable.

We are pleased to offer the following payment options:

- Cash
- Check or Check Card
- Visa, MasterCard, or American Express
- Care Credit (If approved, you have the option of 6 to 18 months interest free!)

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

Your estimated insurance co-pay is expected when services are rendered, unless payment options have been arranged prior to treatment. All new patients are required to pay for their first visit in full unless we have discussed or received your insurance information prior to your appointment, in which you will only be expected to pay your estimated co-pay.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed by you to your insurance carrier.

Note: Please keep in mind that all balances of money owed are personal balances regardless of what your insurance company pays.

I agree that I am fully responsible for the total payment of all procedures performed in this office , this includes any treatment that is or is not a benefit of any dental insurance that I may have.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my health status. We do require a 24 hour notice for canceled appointments, anything less is considered a broken appointment. After a broken appointment, it is at our Doctor's discretion whether or not we will continue seeing you as a patient. We will see you on an emergency basis for two weeks to give you time to find a new dentist.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

_____ _____

Signature Date

Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Warren & Miller Dentistry is authorized to release protected health information about the above named patient to the entities below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to receive information Check below, each person/entity that you approve to receive the information on it's right	Description of Information to be released Check below, information that can be given to the person/entity on it's left
☐ Voice Mail ☐ Text ☐ Email	☐ Results of lab tests/x-rays ☐ Appointment information
☐ Employer ☐ School	☐ Appointment absentee information
☐ Spouse ☐ Parent/Guardian (provide name) _____	☐ Family billing information ☐ Financial ☐ Medical
☐ Dental offices ☐ Medical offices	☐ Patient chart/x-rays (upon your request) ☐ Patient chart/x-rays (upon their request)

Rights of the Patient

I understand that I have the right to revoke this authorization at any time, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document, by sending a written notification to Warren & Miller Dentistry . I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

_____ Date _____

(Signature of Patient or Guardian)