Patient Information:

Name ____ Married ___ Single ___ Male ___ Female ___

Date of Birth: ______/______/______ SS# ______/______/______ Phone: (______)_____________ Cell (______)_____________

Email ____

Address: _______________________________ Unit #: _____ City: _______________ State: ______ Zip__________

Spouse's Name: ________________________ *Whom may we thank for referring you? ________________________

Account Information:

Person who subscribes to insurance ______________________________ Married ___ Single ___ Male ___ Female ___

Date of Birth: ______/______/______ SS# ______/______/______ Phone: (______)_____________ Cell (______)_____________

Address: _______________________________ Unit #: _____ City: _______________ State: ______ Zip__________

Insured party's Employer Name: ____

Employer Address: _________________________________ City: _______________ State: ______ Zip__________

Dental Insurance Information: ***Please fill in all the information. We want to help you to receive the benefits available to you.***

Insurance Co. Name: ____ **Phone:** (______)______________

Group # ___________________________________ **Subscriber #** ______________________________

Address: ___________________________________ **Unit #:** ____ **City:** _____________ **State:** _____ **Zip**_________

Medical Information:

Purpose for this dental appointment: Check-up ___ Consultation ___ Pain ___ Other: ___________________________

Primary Care Physician's Name: ____ Phone: (______)______________

What medications or drugs are you currently taking? ____

Have you had any serious illness? ____ If so, what? ___________________________ Do you smoke? ______

Have you been hospitalized during the past two years? ____ If so, why? ________________________________

Women only: Do you take birth control? ______ Are you pregnant? ______ How many weeks? ______ Are you nursing? ______

Allergies (please circle all that apply):

Aspirin	Erythromycin	Metals	Latex	Sulfa
Codeine	Dental Anesthetics	Amoxicillin	Penicillin	Tetracycline

Other Applicable Allergies: ____

Please circle any of the following you have had:

Heart Attack	Stroke	Hepatitis A or B	HIV/AIDS
Heart Surgery	Artificial Joints/Hips	Asthma	Venereal Disease
Heart Murmur	Kidney Trouble	Cancer	Herpes
High Blood Pressure	Scarlet Fever	Thyroid Disease	Bruise easily
Low Blood Pressure	Sinus Trouble	Cortisone Treatment	Psychiatric Care
Congenital Heart lesions	Emphysema	Arthritis/Gout	Sickle Cell Anemia
Rheumatic Fever	Frequent coughs	Glaucoma	Hypoglycemia
Artificial Heart Valve	Lung Disease	Epilepsy or Seizures	Allergies
Anemia	Tuberculosis	Drug Addiction	Ulcers
Fainting or dizziness	Liver Disease	Hemophilia	Diabetes

Do you require pre medication? _____ **If so what type?** ____

I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due at time of treatment unless prior arrangements have been made. All accounts must be paid within 30 days. In the event that your account becomes delinquent, finance charges will accrue and the patient is responsible for all collections fees. At Piscataqua Dental we have a mandatory 48 hour cancellation notice. A fee of $100.00 will be charged for all failed Doctor Appointments and $50.00 for all failed Hygiene Appointments cancelled without proper 48 hour notice.

SIGNATURE (patient/parent) ____ **Date** _____/_____/________