Alamont Dental Associates, p.c.

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PLEASE COMPLETE THE FOLLOWING

GENERAL INFORMATION

Male ☐ Female ☐

Dr.
Mr.
Ms.
Mrs.
Miss _____ Social Sec. # _____
Last *First* *Middle*

Birthdate _____

Residence
Address _____
Number *Street* *City* *State* *Zip Code* *Area Code* *Telephone*

Patient's Employer Name _____ Occupation _____

Address _____
Number *Street* *City* *State* *Zip Code* *Area Code* *Telephone*

Marital Status _____ Name of Spouse _____

Spouse's Occupation _____ Spouse's Employer _____

If patient is a minor, who is legally responsible? _____
Name *Relationship*

_____
Number *Street* *City* *State* *Zip Code* *Area Code* *Telephone*

Employer of responsible party _____

Social Security # _____ Date of Birth _____

Name and address of nearest relative not living in same household _____

_____
Number *Street* *City* *State* *Zip Code* *Area Code* *Telephone*

DENTAL INSURANCE

Do you have Dental Insurance? ____ Yes ____ No Name of Insurance Company _____

Through what emplorer? _____ Family Members Covered: _____

Employer's Address _____

Policy Number _____ Subscriber Name _____ ID # _____

Subscriber's Social Security # _____ Date of Birth _____

DENTAL HISTORY

Referral Source _____

Date of last dental visit _____ Immediate dental concerns _____

PLEASE TURN PAGE

MEDICAL HISTORY

PLEASE ANSWER EACH QUESTION

YES NO Are you sensitive or allergic to any drug or medication? Please explain: _____

_____

YES NO Are you under the care of a physician? For what? _____

Name _____ City _____

YES NO Are you pregnant? What month? _____

YES NO Are you taking any prescription drugs? Please list:

Taking _____ For_____ Taking _____ For _____

Taking _____ For_____ Taking _____ For _____

Taking _____ For_____ Taking _____ For _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD? *PLEASE CHECK*

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Rheumatic Fever	☐	☐	Heart Bypass	☐	☐	Stroke	☐	☐	Dizziness/Fainting
☐	☐	Heart Murmur	☐	☐	Psychiatric Problems	☐	☐	Diabetes	☐	☐	Thyroid Condition
☐	☐	High Blood Pressure	☐	☐	Nervous Disorders	☐	☐	Cancer	☐	☐	Venereal Disease
☐	☐	Heart Pacemaker	☐	☐	Epilepsy/Seizures	☐	☐	Hepatitis/Liver Disease	☐	☐	Arthritis
☐	☐	Angina	☐	☐	Stomach Ulcers	☐	☐	Kidney/Bladder Disease	☐	☐	Artificial Joint
☐	☐	Heart Disease	☐	☐	Lung Disease	☐	☐	Frequent Severe Headaches	☐	☐	Anemia
☐	☐	Artificial Heart Vaive	☐	☐	Asthma	☐	☐	Bleeding Problems	☐	☐	Radiation Therapy
☐	☐	Mitral Valve Prolapse				☐	☐	HIV	☐	☐	Chemotherapy

YES NO Do you have any disease or condition that is not listed above that you think we should Know about? Please explain: _____

In case of emergency contact: _____ Phone _____

Payment is due when services are rendered unless prior financial arrangements have been made.

Your FINANCE CHARGE is computed by a periodic rate of 1.5% monthly which is an annual percentage rate of 18%, applied to your balance outstanding sixty (60) days or greater. Your balance is due within twenty-five (25) days from the billing date shown on your monthly statement unless you have made other arrangements, plus any reasonable collection expense and attorney fees when applicable.

I hereby authorize you, any credit bureau, or other investigating agency to investigate or obtain any data pertaining to my credit or financial responsibilities.

SIGNATURE REQUIRED

I confirm as true the above health information and realize that withholding any requested information might jeopardize my treatment, health or safety.

Signed _____ Date _____

(Patient, Parent or Guardian)

ALAMONT DENTAL ASSOCIATES, P.C.