TELL US ABOUT YOURSELF

Name: ____ ☐ Male ☐ Female
Last First MI Title (Preferred Name)

Address: ______________________ City ______________ State _____ ZIP _________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced DOB: ____________ SSN: ______________

Home Phone: ______________ Wireless Phone: ______________ E-mail: ______________

Employer: ______________ Occupation: ______________ Work Phone: ______________

Preferred contact method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ E-mail

How did you hear about our office? ____

Cancellation Policy and Consent: Our office requires at least 48 hours advanced notice for any changes or cancellations to your appointment. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time. We do, however, understand that illness and emergencies occur and we do accommodate for those rare instances. A fee of $25 will be charged to your account for not honoring this policy.

I have read the cancellation policy and consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: ____

(Complete this section only if you have insurance)

Insurance – Primary

Subscriber Name: ______________ Relationship to Patient: ____________ Subscriber DOB: ____________

Insurance – Secondary

Subscriber Name: ______________ Relationship to Patient: ____________ Subscriber DOB: ____________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to NDK Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Relationship to Patient: ______________________ Date: ______________________

MEDICAL HISTORY

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No If yes, please list: ____________________

Have you ever had any surgical procedures? ☐ Yes ☐ No If yes, please list: ____________________

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Allergies
☐	☐	Abnormal Bleeding	☐	☐	Heart Murmur	☐	☐	Aspirin
☐	☐	Alcohol Abuse	☐	☐	Hepatitis	☐	☐	Codeine
☐	☐	Anemia	☐	☐	High Blood Pressure	☐	☐	Dental Anesthetics
☐	☐	Asthma	☐	☐	Joint Replacement	☐	☐	Erythromycin
☐	☐	Blood Transfusion	☐	☐	Kidney Problems	☐	☐	Jewelry/Metals
☐	☐	Cancer	☐	☐	Liver Disease	☐	☐	Latex
☐	☐	Chemotherapy	☐	☐	Psychiatric Problems	☐	☐	Penicillin
☐	☐	Diabetes	☐	☐	Radiation Therapy	☐	☐	Tetracycline
☐	☐	Difficulty Breathing	☐	☐	Rheumatic Fever			
☐	☐	Drug Abuse	☐	☐	Seizures	Yes	No	**If Female, Please Answer**
☐	☐	Emphysema	☐	☐	Sexually Transmitted Disease	☐	☐	Are you taking Birth Control Pills?
☐	☐	Epilepsy	☐	☐	Shingles			
☐	☐	Facial Surgery	☐	☐	Sinus Problems	☐	☐	Are you pregnant?
☐	☐	Fainting Spells	☐	☐	Stroke			If so, # of Weeks ________
☐	☐	HIV + AIDS	☐	☐	Thyroid Problems	☐	☐	Are you nursing?
☐	☐	Heart Problems	☐	☐	Tuberculosis			

Do you have a personal physician? ☐ Yes ☐ No

If yes, Physician's Name: ____________________ Phone: ____________ Date of last visit: __________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: ______________________________ Date: ____________________