



WELCOME

PERSONAL INFORMATION

Name _____ Name you wish to go by _____
 () Male () Female () Single () Married Birth date _____ Social Sec # _____
 Home Address _____
 Apt # _____ City _____ State _____ Zip _____
 Mailing Address _____ City _____ State/Zip _____
 Name of Spouse _____ Emergency Contact _____ Phone _____
 Occupation _____ Employer _____
 Home phone _____ Work phone _____ ext _____ Cellular phone _____
 Email _____ Who may we thank for referring you? _____

RESPONSIBLE PARTY The following is for the person responsible for payment.

Name _____ Relationship to patient _____
 Home Address _____ City _____ State/Zip _____
 Mailing Address _____ City _____ State/Zip _____
 Birth Date _____ Driver's License # _____ Social Sec # _____

INSURANCE

Primary

Name of Insured _____ Is insured a patient? ____ Yes No
 Insured's Birth Date _____ ID # _____ Group # _____
 Insured's Employer Name _____ Insurance Plan Name _____

Secondary

Name of Insured _____ Is insured a patient? ____ Yes No
 Insured's Birth Date _____ ID # _____ Group # _____
 Insured's Employer Name _____ Insurance Plan Name _____

HOW DID YOU HEAR ABOUT OUR OFFICE

- () Newspaper () Friend () Television () Internet
 () Yellow Pages () Sign () Mall Kiosk () Other

If other please explain: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor. I understand that my dental care insurance carrier benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of accounts & if turned over for collection I will be responsible for collection fees. By signing this statement I agree to be responsible for payment of services not paid, in whole or in part by my dental or medical payor.

I am aware that dental treatment on rare occasion can result in situations including: loss of teeth, swelling, bleeding, numbness and infection. I consent to treatment being aware of possible consequences. I have read the Consent for Services and agree to their content.

Signature of patient, parent or guardian _____ Date _____ Relationship to Patient _____



MEDICAL HISTORY

What medications are you taking including over the counter medicines or herbal supplements
i.e. aspirin, vitamins, etc.? _____

Are you on Coumadin or other blood thinners Yes No

Are you allergic to anything? Penicillin Codeine Latex Other _____

Are you diabetic? Yes No

Do you have: Hepatitis HIV AIDS

Are you pregnant? Yes No If yes, how many weeks are you? _____

Do you have: Artificial Heart Valve Infective Endocarditis

Have you ever been told you need to premedicate for a dental visit? Yes No

Do you snore? Yes No

Do you wake up in the morning with headaches? Yes No

Have you been told that you gasp for air or suddenly stop breathing while sleeping? Yes No

Have you ever had an overnight sleep study? Yes No

Have you ever been diagnosed with Sleep Apnea? Yes No

Do you or have you used a CPAP? Yes No

PERSONAL HABITS

How many soft drinks/juice drinks do you drink daily? _____

Do you chew gum? Yes No

Do you smoke or use smokeless tobacco? Yes No

PHYSICIANS

Please list your primary medical doctor:

Name: _____ Phone _____

Treatment: _____

Anything else we need to know about your health

What is the first thing you would like for us to help you with?

AUTHORIZATION AND RELEASE

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Signature of patient, parent or guardian Date _____ Relationship to Patient _____

I authorize Dr. Lynch and/or his team to release any information concerning my dental treatment to third party payers and or health practitioners.

Signature of patient, parent or guardian
We are very proud of the work we have done and only use our own patients in marketing and advertising. All of the portraits in our office, on our web site, and in our ads are our own patients and photography.

I, _____, hereby authorize Dr. Steve Lynch and/or his team to take and display photographs

Signature of patient, parent or guardian