ADVANCE Dental Art

We are pleased to welcome you to our practice! Please take a few minutes to fill out this form as completely as possible. If you have any questions we will be happy to help.

Personal Information

Last Name: ______ **First Name:** ______ **Home Address** ______
Soc Sec # - - **Sex:** M ◎ F ◎ **City:** ______ **State:** ______ **Zip:** ______
Phone: ( ) ______ **Marital Status:** ______
Cell Phone ( ) ______ **E-mail:** ______
Wk Phone: ( ) ______ **Occupation:** ______
Birth date: ______ **Age:** ______ **Company:** ______
DL# ______ **Work Address:** ______
How did you hear about us? ______ **City:** ______ **State:** ______ **Zip:** ______

Dental Insurance Information

Person Responsible for the account: ______ **Relationship to the patient:** ______
Soc Sec # - - **Address:** ______
Birth date ______ Age ______ **City:** ______ **State:** ______ **Zip:** ______
Insurance Company: ______ **E-mail:** ______
Insurance Address: ______ **Occupation:** ______
______ **Company:** ______
Insurance Phone: ( ) ______ **Work Address:** ______
Contract #: ______ **Group #:** ______ **Subscriber #:** ______
Max Benefits per year: ______ **Annual Deductible:** ______ **Used this year:** ______

Dental History

What would you like done today? ______
Former Dentist: ______ **Phone Number:** ______
Date of last Visit: ______ **Are you in Discomfort?:** ______
Check if you have had problems with any of the following:

◎ **Bad Breath**	◎ **Food between Teeth**	◎ **Sensitivity to cold or hot**
◎ **Bleeding Gums**	◎ **Grinding Teeth**	◎ **Sensitivity to sweets**
◎ **Clicking Jaw**	◎ **Loose Teeth:**	◎ **Sores or growths in Mouth**

Notes

______

Authorization

I have reviewed the information in this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment. If there is any change to my medical status, I will inform the dentist. I authorize my insurance to pay all benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that **I am financially responsible for all charges whether or not paid by insurance**. I understand that there is a $50 Cancellation fee for all appointments canceled without 48 hours notice and I agree to pay such fees. I understand that the dental office will allow 30 days for the collection from the insurance company, but after that point, I will pay the remaining balance. In addition I will pay any legal cost or finance charges the dental office incurs while attempting to collect the debt.

Signature: ______ **Date:** ______

(Medical History on Reverse Side, Please turn over and complete)