Welcome to Our Practice

Patient's Name: _____Nickname:_____
Guardian (if patient is a minor):_____
Birthdates: ____/____/____ SS#:_____ Home Phone (Area Code) :(____) _____
Work Phone (Area Code) :(___) _____ Mobile Phone (Area Code) :(____) _____
Mailing Address: _____Zip Code: _____
Email Address: _____

Employer:_____
How Long: _____Occupation:_____
Status: _____Minor:_____Single:_____Married:_____Divorced:_____Separated:_____Widowed

Spouse's Name: _____Do you have children? Yes/No How Many? _____
Names: _____
Person Financially responsible for account: _____
Relation to Patient::_____
Address: _____Zip Code: _____
Phone Numbers Home: _____Work:_____
Contact in case of an Emergency: _____

Dental Insurance: Please Present Card to Receptionist

Primary Dental Insurance Company: _____
Policyholder: _____ID#:_____
Policyholder's: Place of Employment: _____
Policyholder's Date of Birth: ____/____/____ SS#:_____
Secondary Dental Insurance Company: _____
Policyholder: _____ID#:_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above insurance carrier and assign directly to John J. Andre, DDS,PC 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____Date:_____

How did you hear about our office? Yellow Pages: _____Yellow Book _____ Insurance: _____
Internet : _____ Location_____

Referred By: _____

Please fill out reverse side

Dental Information

Reason for today's visit:_____Exam _____Emergency _____Consultation
Are you in pain? _____Yes _____No How Long? _____
Please check if you have:

_____ Discomfort, clicking or popping in jaw
_____ Red, Swollen or Bleeding Gums
_____ Sensitive Tooth, Teeth or Gums
_____ Blisters/ Sores in or Around Mouth
_____ Broken/ Chipped Tooth
_____ Snoring / Sleep Apnea
_____ Lost/Broken Fillings
_____ Teeth Grinding
_____ Stained Teeth
_____ Locking in Jaw
_____ Bad Breath

Are you happy with your smile? _____Yes _____No
Would you like a brighter smile? _____Yes _____No
Would you like to change anything? _____Yes _____No
If answered yes what would you like to change:_____

Do You Require Pre-medication? _____

Previous Dentist: _____ Phone: _____
Last Dental Exam: _____ Last Dental X-ray: _____
Times a Day You Brush? _____ Times a Week You Floss? _____

Medical History

Circle any of the following, which you have had or now have:

Aids/HIV	Congenital Heart Lesions	High/Low Blood Pressure
Anemia	Diabetes	Jaundice
Arthritis	Drug Addiction	Kidney Treatment
Artificial Joints	Epilepsy	Pain in Jaw Joints
Artificial Heart Valve	Fever Blisters	Psychiatric Treatment
Asthma	Heart Murmur	Sinus Trouble
Cancer	Hemophilia	Stroke/ Heart Attack
Cardiac Pacemaker	Herpes	Tuberculosis (TB)
Chemotherapy	Hepatitis	Venereal Diseas

Other:_____

List of Current Medications:_____
_____

Are You Allergic to any of the Following? _____Penicillin/Amox _____Codeine _____Latex
_____Tetracycline _____ Erythromycin _____ Sulfa _____ Other

For Women Only: Are You Pregnant? _____ If Yes, What Month? _____
Are You Nursing? _____

- Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the office manager. If the account is not paid within 90 days of the date of service and no financial arrangements have been made you will be responsible for legal fees, collection agency fees, interest charges and other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform of any changes to the information I have provided.

Signature: _____ Date: _____