WELCOME TO OUR OFFICE

Dr. Robert Spoont & Associates
General Dentistry

PATIENT INFORMATION

Patient Name:_____ Today's Date_____
Last First MI

□ Male □ Female □ Mr. □ Mrs. □ Ms. □ Miss □ Dr.

Social Security # _____ Date of Birth _____

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Address _____
Street Apartment #

_____
City State Zip Code

E-MAIL ADDRESS (Needed to Confirm Appointments)_____

Marital Status: [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Single

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HEALTH INFORMATION

Date of Last Dental Visit:_____ Date of last x-rays_____ Name of Previous Dentist_____

Have you ever had any complications following dental treatment? □ yes □ no

If yes, please explain_____

Have you been admitted to a hospital or needed emergency care during the past two years? □ yes □ no

If yes, please explain_____

Are you now under the care of a physician? □ yes □ no If yes, please explain _____

Are you now taking any medication? □ yes □ no If yes, please list _____

Name of Physician: _____ Phone_____

Have you ever had any of the following? Please check those that apply:

□ AIDS OR HIV Positive	□ Blood/Bleeding disorder	□ Heart Disease/Surgery	□ Pregnant Now?
□ Allergies: Penicillin	□ Cancer	□ Heart Murmur/Rheum. Fever	□ Radiation/Chemotherapy
□ Allergies: Codeine	□ Diabetes	□ Stomach Problems/Ulcer	□ Stroke
□ Allergies:_____	□ Dizziness/Fainting	□ Hepatitis (Liver Disease)	□ Tuberculosis
□ Anemia	□ Ear Disease	□ High Blood Pressure	□ Tumors/Growth
□ Arthritis/Joint Disease	□ Epilepsy/Seizures	□ Kidney Disease	□ Venereal Disease
□ Artificial Joints	□ Eye Disease	□ Mental/Nervous Disorder	□ Other_____
□ Asthma/Resp. Disease	□ Glandular/Hormonal Dis.	□ Pacemaker	□ Other_____

Do you have any health problems that need further clarification? □ yes □ no

If yes please explain:_____

Emergency contact other than your spouse: Name_____Phone:_____Relation:_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?_____

Please list any other immediate family members who are patients of this office_____

_____

FINANCIAL INFORMATION

Who will pay account?_____ Relationship to patient_____

YOUR EMPLOYMENT: **SPOUSE'S NAME:**_____

Occupation_____ Spouse's occupation _____

Employer_____ Employer_____

Work Address_____ Work Address_____

City_____ State_____ Zip_____ City_____ State_____ Zip_____

Your Social Security # _____ Your Social Security # _____

Driver's license #_____ Driver's license #_____

If paying by check: Bank name_____ Branch _____ Account #_____

DENTAL INSURANCE INFORMATION

Primary: Name of insured:_____ Is insured a patient? □ Yes □ No

Insured's birth date:_____ID #_____ Group #_____

Insured's address:_____

Street City State Zip

Insured's Employers Name_____

Address:_____

Street City State Zip

Patient's relationship to insured: □ Self □ Spouse □ Other_____

Insurance plan name:_____

Address:_____

Street City State Zip

Secondary: Name of insured:_____ Is insured a patient? □ Yes □ No

Insured's birth date:_____ID #_____ Group #_____

Insured's address:_____

Street City State Zip

Insured's Employers Name_____

Address:_____

Street City State Zip

Patient's relationship to insured: □ Self □ Spouse □ Other_____

Insurance plan name:_____

Address:_____

Street City State Zip

AGREEMENT FOR DENTAL SERVICES

1. **The patient (or if a minor, parent(s) or legal guardian) hereby retains either Dentist or their associates to render dental services to and for the benefit of the patient.**
2. **The patient (parent or legal guardian) hereby agrees to pay for all the bills and charges for services promptly. The charges are due at the time services are rendered.**
3. **The patient (parent or legal guardian) acknowledges that he/she is responsible for all charges incurred in the rendering of dental services, regardless of what type of insurance he/she carries. Any action by this office to process applications for insurance or other benefits on behalf of the patient will not relieve the patient of the obligation to pay the bill. The patient further understands that any failure by the insurance company or other provider of benefits to pay for all or part of the patient's bill will not excuse the obligation to pay all the amount for service rendered. Our office will make every effort to assist you in filing and processing claims.**
4. **In the event that this office finds it necessary to resort to collection action due to an unpaid bill, the patient (parent or legal guardian) agrees to pay all cost, expenses, and attorney's fees associated with collection.**
5. **I authorize Freedman & Spoont to bill my insurance carrier for services rendered.**

_____ _____ _____

Signature of patient, parent or guardian **Date** **Relationship to patient**

07/06