



Thank you for visiting *Volner Family Dental*. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

CITY STATE ZIP

Birth date _____ Social Security # _____

Employer _____ May we contact you at work? Yes No

Phone: Home (____) _____ Email: _____

Work (____) _____ Mobile (____) _____

Emergency Contact _____ Phone (____) _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

CITY STATE ZIP

Telephone (____) _____

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE/ PARENT/GUARDIAN IF REQUIRED

DATE

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like most about your last dentist? _____

Medical History and Information

Conditions

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Heart Valve
- Asthma
- Blood Transfusion
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV+ Aids
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Joint Replacement
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Sexually Transmitted Disease
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline

Other _____

Y N

- Do you Smoke
or use Tobacco?

If Female

Y N

- Are you taking Birth
Control Pills?

- Are you pregnant?
If yes, # of weeks _____

- Are you Nursing?

Please list any medications
you are currently taking: _____

Appointment Policy

When you request an appointment, we reserve the time exclusively for you. We request 24 hours notice for appointment cancellation. You will be charged for broken appointments if 24 hour notice is not given, unless an emergency.

PATIENTS SIGNATURE/ PARENT/GUARDIAN IF REQUIRED

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have had a chance to read or have received a copy of
this office's Notice of Privacy Practices (standard HIPPA notice). *You May Refuse To Sign This Acknowledgement

Please Print Name

Signature

Date