It is our office policy that these and any other forms filled out and signed by the patients will be part of our office records.

PATIENT INFORMATION

Name: Date of Birth:

How did you hear about us? Last Dental Visit:

Purpose of this Visit:

Address:

City: State: ZIP Code:

Home # Cell #

Receive Text Correspondence? (Circle one) Yes No

Employer: Business #

Social Security Number:

E-Mail Address:

Emergency Contact: Phone #

Relation:

MEDICAL HISTORY

Write in Yes or No	Give details under "Remarks" for any yes answer
	1. Have You ever been treated for any heart condition, high blood pressure or any prolonged illness such as diabetes, asthma kidney disease, HIV+, etc.?
	2. Have you ever had prolonged bleeding from injury, tooth extractions, etc?
	3. Have you ever had a heart murmur or rheumatic fever?
	4. Are you allergic to any drugs (penicillin), foods, materials or pollens?
	5. Have you ever had a reaction from any anesthetics?
	6a. Are you presently or have you, during the past two years, been under the care of a physician?
	6b. If you are a woman, are you pregnant?
	7. Do you have or have you recently had any evidence of infections, such as boils, infected wounds, severe sore throat or persistent cough?
	8. Have you ever had any illness or complication following dental treatment of any kind?
	9. Have you ever had any other illness or condition other than the common cold, virus or flu?
	10. Do you have reason to believe that you are not presently in good health?
List medications you are taking:	
Any Allergies? (i.e. Latex):	
REMARKS:	
Signature:	**Date:**

INSURANCE INFORMATION

Name of Insurance Company:		Subscriber Name:
Insurance Company Address:		Subscriber Address:
Date of Birth (MM/DD/CCYY)	Gender M ☐ F ☐	Policyholder SSN # Policyholder ID#
Plan/Group #	Employer Name:	
Relationship to Policyholder:	Self ☐ Spouse ☐ Dependent Child ☐ Other ☐	

INSURANCE AUTHORIZATIONS

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____

Patient/Guardian Signature Date

I hereby authorize and direct payment of the dental benefits (otherwise payable to me), directly to Sunrise Dental Service Bohemia, NY 11716

X_____

Patient/Guardian Signature Date

RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself or for:

_____ Age:_____

_____ Age:_____

_____ Age:_____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

_____ _____

Signature of responsible party Relationship to other(s) named

MISSED APPOINTMENT POLICY

If you are unable to keep your scheduled appointment, please give us notice at least **48 hours in advance** to ensure that you will not be charged.

For any cancellation notice of less than 48 hours or no show appointments, there will be a charge of $45 per appointment.

X_____

Patient/Guardian Signature Date

SMILE EVALUATION

Answer these questions as honestly as you can.

Do you like the appearance of your smile? ☐ YES ☐ NO

Do you like the appearance of your teeth? ☐ YES ☐ NO

Do you like the color of your teeth? ☐ YES ☐ NO

Would you like to discuss how to make your teeth WHITE? ☐ YES ☐ NO

Do you have spaces between your teeth that you don't like? ☐ YES ☐ NO

Do you like the size and shape of your teeth? ☐ YES ☐ NO

Are there old fillings or dental work you don't like looking at? ☐ YES ☐ NO

What would you like to change about the appearance of your teeth?

_____

_____

_____

_____