

Hammer Dental Associates

Patient Information

Name: _____ Birthdate: ____ - ____ - ____ Social Security # _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

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

Employer: _____ Email Address: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Whom May We Thank For Referring You? _____

Person to Contact in Case of Emergency: _____

Insurance Information

Name of Insured: _____ Relationship: _____ Birthdate of Insured: ____ - ____ - ____

Social Security # ____ - ____ - ____ Employer: _____ Work Phone: (____) _____

Address of Employer: _____ City: _____ State & Zip: _____

Insurance Company: _____ Group# _____ Policy/ID# _____

Patient Medical History

Physician: _____ Office Phone: _____ Date of Last Exam: _____

Are You Under Medical Treatment Now? _____ Blood Pressure: _____

Are You Taking any Medications? If yes, list: _____

Are You Allergic to any Medications? Penicillin__ Aspirin__ Ibuprofen__ Codeine__ Anesthetics__ Latex Rubber__ Other _____

Do You Have any Medical Problems? Blood Pressure__ Heart Problems__ Rheumatic Fever__ Diabetes__ Kidney Disease__ TB__

Aids or HIV Infection__ Liver Disease__ Anemia__ Venereal Disease__ Asthma__ Cancer__ Other _____

Are You Pregnant or Think You Are? __ Are You Nursing? __ Are You Taking Birth Control Pills? __

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to my dependent or myself during the period of such dental care to third party payers' and or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment if all services rendered on my behalf or my dependents, including all collection fees if necessary. Accounts over 60 days are subject to a 2% interest rate/month, 24% per year.

X _____ Date: _____
Signature of patient (or parent if minor)