basalt DENTISTRY

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Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. **Please fill out this form as completely as possible.** The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date: _____ How did you hear about us? _____

Name (First, Middle, Last): _____

I prefer to be addressed as: _____ Circle One: **Male** **Female**

Birthdate: _____ Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

City: _____ State: _____ Zip: _____

Circle One: **Single** **Married** **Widowed** **Divorced** **Separated** **Partnered**

EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

DENTAL INSURANCE

Person Responsible for Account (If other than yourself): _____

Do you have dental insurance coverage? **Yes** **No**

Dental Insurance Co. Name: _____

Dental Insurance Co. Phone: _____

Group # (Plan and Policy#): _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: _____ SS#: _____

Insured's Employer: _____ Occupation: _____

ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

I understand that I will be required to pay my **estimated** portion of Dr. Jonathan Haerter's/ Basalt Dentistry's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement. **See additional financial policies on Page 3...**

Signature: _____

Date: _____

MEDICAL / DENTAL HISTORY

Do you have a physician? **Yes** **No** Physician's Name: _____ Phone: _____

Date of Last Physical: _____

Current Physical Health: **Excellent** **Good** **Fair** **Poor** **Very Poor**

Are you currently taking any prescription medications? **Yes** **No**

Please List Medications with Correlating Diagnosis: _____

_____

Date of last dental visit: _____ Reason for today's visit / main concern? _____

ALLERGIES - Circle any and all of the following to which you are allergic:

Aspirin	**Dental Anesthetic**	**Jewelry/Metals**	**Penicillin**
Barbiturates/Sleeping Pills	**Erythromycin**	**Latex**	**Tetracycline**
Codeine	**Ibuprofen/Motrin**	**Percocet**	**Vicodin**

Please list any other medications and/or materials to which you think you are allergic: _____

_____