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)