Thank you for visiting our office! We want your visit to be pleasant and comfortable.
Please assist us by completing this form entirely. (Please print):

Patient Information:

Name: _____
Last First Middle Initial

Preferred Name:_____

Address:_____
House#/Street Name City State
Zip _____

Employer:_____ Occupation:_____

Date of Birth: _____ Driver's License: _____

Social Security Number: _____-_____-_____ Email:_____

Preferred Contact Number: (____) _____-_____ (circle) : Home Cell Work
Alternate Contact Number: (____) _____-_____ (circle): Home Cell Work

Emergency Contact Name: _____ Phone: (_____) _____-_____

Relationship of Emergency Contact: _____

Berger Family Dental has my permission to (please check):
_____ Leave voicemails on the phone numbers I've provided
_____ Contact me via email for appointment reminders

If patient is a Minor, Responsible Party Name: _____
Address: _____ Phone (____) _____-_____
Relation to Patient: _____

Insurance Information:
Primary Dental Carrier Company Name: _____
Insurance Carrier's Phone: (_____) _____-_____
Name of Subscriber: _____ Date of Birth: _____
Social Security Number: _____-_____-_____ Relation to Patient: _____
Group Number: _____ ID Number: _____

Secondary Dental Carrier Company Name: _____
Insurance Carrier's Phone: (_____) _____-_____
Name of Subscriber: _____ Date of Birth: _____
Social Security Number: _____-_____-_____ Relation to Patient: _____
Group Number: _____ ID Number: _____

Insurance Authorization Statement: (Sign & Date):
I hereby authorize the Practice to file claims on my behalf. I 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 of dental treatment not paid by my insurance carrier for any reason.

Signature Patient/Parent/Guardian: _____ Date: _____

PATIENT NAME:_____ **DOB:** _____

DENTAL HISTORY:

What is the main reason for your visit today? (Please check one):

□ Tooth Pain □ Whitening □ Denture(s)
□ Check-Up □ Extractions □ Cosmetic Dentistry
□ Cleaning □ Braces □ Other: _____

Date of Last Cleaning/Hygiene Visit: _____

Reason for leaving your last Dentist:_____

Have you ever been treated for TMJ disorder? □ Yes □ No

Do you suffer from headaches or tenderness in jaws? □ Yes □ No

How did you hear about our office? □ Friend/Existing Patient's Name: _____

□ Phonebook □ Insurance Website □ Driving By □ Advertisement Name_____

□ Other: _____

I would like to learn more about: □ Whitening □ Cosmetic Dentistry □ Implants □ Veneers □ Bridges

□ Dentures □ Braces □ Other: _____

MEDICAL HISTORY: (Please check)

□ Abnormal Bleeding
□ Alcohol/Drug Abuse
□ Anemia
□ Angina Pectoris
□ Artificial Heart Valve
□ Asthma
□ Blood Transfusion
□ Cancer
Type: _____
Date of Diagnosis: _____
□ Chemotherapy
□ Diabetes
□ Difficulty Breathing
□ Epilepsy/Seizures
□ Fainting
□ Fever Blisters
□ Glaucoma
□ HIV+ Aids
□ Mitral Valve Prolapse
□ Heart Attack
Date:_____
□ Heart Surgery
*Date:*_____
□ Heart Disease
□ Hepatitis
Type:_____
□ High Blood Pressure
□ Joint Replacement
Type: _____
Date: _____
□ Kidney Problems
□ Liver Disease
□ Pacemaker/Defibrillator
□ Psychiatric Disorders
□ Radiation Therapy
□ Rheumatoid Arthritis
□ Sexually Transmitted Diseases
□ Shingles
□ Sickle Cell
□ Sinus Problems
□ Stroke
□ Hypothyroid
□ Hyperthyroid
□ Tuberculosis
□ Tobacco use

ALLERGIES:

□ Aspirin
□ Anesthetics
□ Latex
□ Penicillin
□ Codeine
□ Sulfa
□ Other: _____

FOR FEMALES:

□ Pregnant? # Weeks: _____
□ Nursing □ Birth Control Pills

□ **Have you had any illness not listed**? _____

Medication Name/Dosage	***Frequency***	***Reason for Taking***

****Please let us know if additional space required****

If a healthcare worker in this office is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne disease to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). **Signature:** _____

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

Patient Signature/Parent or Guardian: _____ **Date:** _____