Full Name _____
Street Address _____
City _____ State ____ Zip _____
Employer _____ How long? _____
Spouse Name _____
Spouse Employer _____ Phone _____
Dependent Children Names/Birthdays _____
Other Family Seen Here _____
Last Dental Visit _____ Dentist's Name _____
Email _____ Cell Phone_____
Your email/cell will ONLY be used for communications between you and this office.

Preferred Name _____
Birthday _____
Home Phone_____
Work Phone _____
Soc. Sec. # _____
Marital Status _____
Referred by: (please circle)
Family Friend Co-worker
Other _____
Name of person who referred you:
_____

Please circle any of the following which you feel need attention, or would like to discuss:
Toothache Cavities Bleeding/Infected Gums Bad Breath/Taste Broken Teeth Chewing Pain Missing Teeth Hot/Cold Sensitivity
Appearance Failed Fillings Dentures/Partials Implants Bonding Crowns Full Mouth Rehabilitation
How apprehensive are you about dental care (circle) NOT AT ALL A LITTLE VERY TERRIFIED

Please circle if you have, or have had, any of the following:

Arthritis	Hay Fever	Pacemaker	Allergy/Reaction to:
Artificial Joints	Head Injuries	Pregnant at present time	Anesthetics
Asthma	Heart Disease/Attack	Radiation Treatment	Antibiotics
Blood Disorder	Heart Murmur	Respiratory Problems	Aspirin/Tylenol
Cancer	Heart Stent	Rheumatic Fever	Codeine
Chemotherapy	Hepatitis	Rheumatism	Ibuprofen
Diabetes	High Blood Pressure	Sinus Problems	Latex
Dizziness	HIV, AIDS, ARC	Stomach Problems	Nickel or other metals
Epilepsy	Jaundice	Stroke	Other:
Excessive Bleeding	Kidney Disease	Tuberculosis	_____
Fainting	Liver Disease	Tumors	_____
Glaucoma	Lung Problems	Ulcers/GERD	_____
Growths	Mental Disorders	Venereal Disease	_____

If you have been told by a doctor to take any medications prior to dental treatment, please explain:

Please list any medications you are currently taking, and what they are for in general terms:

Have you ever had any complications during or following dental treatment? NO YES (please explain)

Are you now under the regular care of a physician? NO YES Physician's name _____
Do you have any health problems that need further clarification? NO YES (please explain below)

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any changes in my health or medications, I will the inform the dentist or his assistants at the next appointment without fail.

_____ _____
Signature of patient, parent, or guardian Date

Updated: _____ _____ _____ _____ _____ _____ _____

Dental Insurance Information:

_____ **I am the policy holder (the guarantor)**
Insurance Company _____

_____ **Someone else is the policy holder. Relationship** _____

Name of policy holder _____
Social Security # _____ **Date of Birth** _____
Employer _____ _____ _____
Insurance Company _____

Legal Mumbo Jumbo

William L. Hand III DDS PA is a fee for service dental practice. The office strives to provide excellent dental care as pleasantly and conveniently as possible, but expects to be paid. All adult patients, or parents/guardians, are responsible for payment of all dental services rendered. Payment is expected when services are rendered unless other arrangements are made, in writing. Cash , checks, Visa, Mastercard, and Discover are accepted. Financing is available for qualified individuals through Care Credit.

The office can and will file dental insurance claims as a courtesy, and will credit any payments from insurance companies to the your account. The staff will do their best to help you take full advantage of your benefits, but the insurance contract is between you and your employer/insurance company. We try, but cannot be experts and/or always current on the hundreds of different policies we see. Sometimes, despite everyone's best efforts, insurance payments are not as expected and/or disputes irresolvable. You are responsible for charges your insurance company does not pay.

A service charge of 1 1/2% per month (18% per annum) on unpaid balances may be charged on accounts exceeding 60 days past due. Interest is not charged on pending insurance claims.

I authorize release of any pertinent information relating to my treatment to my insurance company, and authorize the insurance company to make payments on my behalf to this office.

I grant this office permission to contact me as necessary to discuss matters related to my treatment and my account.

I agree, should legal action become necessary to collect a debt to this office, that the prevailing party shall be responsible for legal and collection fees.

I have been provided with a copy of the Notice of Privacy Practices for this office.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____
Signature of patient/parent/guardian **Date**