

VILLAGE DENTAL

AUBURN, ALABAMA

Welcome! Please take a few minutes to fill out this form front and back. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____

Name (Last) _____ (First) _____ (MI) _____ Preferred Name _____

Sex M F Age _____ Birthdate _____ Social Security No. _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Preferred # to call during the day _____

Email Address _____ Marital Status _____

Are you a full time student? Yes No If so, where? _____

Employed by _____ Who may we thank for referring you to our office? _____

Spouses Name _____ Employed by _____ Phone _____

In case of emergency, who should be notified? _____ Phone _____

Responsible Party Information

(If different from patient)

Name (Last) _____ (First) _____ (MI) _____ Marital Status _____

Relation to the Patient _____ Birthdate _____ Soc. Sec. No. _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Drivers License # _____

Employed by _____ Work Phone _____

Dental Insurance

Is the patient covered by dental insurance? Yes No
If yes, we would like to make a copy of your insurance card.

Subscriber's Name (Last) _____ (First) _____ (MI) _____

Relation to the Patient _____ Birthdate _____ Soc. Sec. No. _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Phone _____

Employed By _____ Contract #: _____

Insurance Company _____ Group # _____ Insurance Co. Phone _____

Names of other dependents covered under this plan _____

Additional Dental Insurance

Is the patient covered by 2nd insurance? Yes No
If yes, we would like to make a copy of your insurance card.

Subscriber's Name (Last) _____ (First) _____ (MI) _____

Relation to the Patient _____ Birthdate _____ Soc. Sec. No. _____

Dental History

Reason for Today's Visit _____

Check () if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sensitivity or growths in your mouth |
| <input type="checkbox"/> TMJ Problems | <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Stained or discolored teeth |

How often do you floss? _____ How often do you brush? _____

Former Dentist _____

Address _____

City _____ State _____ Zip _____ Phone _____

Date of last dental care _____ Date of last dental X-rays _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Are you allergic to latex? Yes No Have you ever had a reaction to jewelry or metals? Yes No

(Women) Are you pregnant? Yes No If yes, approximate due date _____

Check () if you have had problems with any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Feet or Ankle Swelling |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |

Please describe a condition if not listed above: _____

Do you premedicate prior to your dental visits? Yes No

If so what medication do you take? _____

MEDICATIONS (list any medications you are currently taking including OTC):

ALLERGIES

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information to secure the payment of benefits.

I give Village Dental Care and/or their agents authorization to contact me at any/all of the phone numbers (including the cell #) for the purpose of treatment, insurance or payment. I agree, that for Village Dental to service my account or to collect monies I may owe, Village Dental Care and/or their agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to you. Village Dental and/or their agents may also contact me by sending text messages or emails, using any email address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that, Village Dental Care its employees, and/or agents, may contact me/us by any permissible method described above. I agree that any permissible contact may include the use of pre-recorded and/or artificial voice messages and/or the use of an automatic telephone dialing system.

I understand that I am financially responsible for all charges whether or not paid by insurance. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State. **I agree to pay uncollected balances and the finance charges, collection fees, and any additional costs related to the collection process. If a check is returned, there will be a returned check fee assessed for a minimum of \$30.00.**

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.