PATIENT INFORMATION

Name ______________________________ Date ______________

Social Security # ______________________________ Date of Birth ______________

Mailing Address ______________________________ City ______________

State ______________ Zip ______________ Phone ______________

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married Cell Phone ______________

Occupation (or occupation of parent or spouse) ______________________________

Employer ______________________________ Employer Phone ______________

Are you prepared to pay for this visit ______________________________

Who will be responsible for this account ______________________________

Dental Insurance Yes ________ No________ Name and address of company______________________________

______________________________ City ______________ State ______________

Medicaid Yes ________ No ________ I.D. # ______________________________

Whom may we thank for referring you ______________________________

In case of emergency, Notify ______________________________Phone ______________

MEDICAL HISTORY

General Health: Excellent Good Fair Poor

If female, are you pregnant ______________________________ How long ______________

Who is your physician ______________________________ Address______________________________

Did you ever have (yes or no):

__________ Kidney Disease	__________ Epilepsy	__________ Allergies
__________ Rheumatic Fever	__________ Diabetes	__________ Heart Valve Replacement
__________ Liver Disease	__________ Heart Trouble	__________ Artificial Joint (Hip, Knee, etc.)
__________ Hepatitis	__________ High Blood Pressure	__________ AIDS/HIV

Are you allergic to (please check):

__________ Penicillin __________ Codeine __________ Novocaine

__________ Other (specify) ______________________________

Are you subject to prolonged bleeding ______________________________

Are you presently taking any medication Yes __________ No __________

If so, what ______________________________

I verify the above and give my consent for treatment.

____

Signature of patient (if child, signature of parent or guardian)

FORM 142126 R/01/13 ITEM 8101

SIGNATURE ON FILE

Bristol Dental Clinic
12761 NW Pea Ridge Rd
Bristol, FL 32321

Dr. Laban Bontrager, DMD
Dr. Monica Bontrager, DMD

- ☐ I authorize use of this form on **ALL** my insurance submissions.
- ☐ I authorize release of information to **ALL** my **Insurance Companies**.
- ☐ I understand that **I am responsible** for my bill.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- ☐ I authorize payment direct to my Doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.

Name: ______________________________
(Please print)

Signature: ______________________________

Date: ______________________________

Electronic Contact Information

May we contact you regarding appointments via: Email ☐ Yes ☐ No
Text message ☐ Yes ☐ No

Email Address: ______________________________

Cell Phone #: ______________________________