HARVEY AND NICHOLS FAMILY DENTISTRY

NEW PATIENT ACQUAINTANCE FORM

Patient's Full Name:_____ Male/Female DOB:_____

Please circle: child single married divorced widowed Preferred Name:_____

Patient Social Security #:_____ Driver's License #:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Work Phone:_____ Email Address:_____

Patient Employed by: (if student – name of school):_____

Name of Spouse:_____ DOB:_____

Spouse Employed by:_____

Person Responsible for Account If Patient Is Under The Age of 18:_____

Responsible Party's Social Security #:_____ Driver's License #:_____

Whom may we thank for referring you?_____

Please check if you have ANY of the following health concerns:

____Heart problems	____High or low blood pressure	____Mitral valve prolapse
____Latex Allergy	_____Rheumatic heart disease	____Kidney or liver disease
____Tuberculosis	____Thyroid disease	____Asthma
____Epilepsy or Seizures	____Arthritis	____Hepatitis
____Diabetes	____Cancer	____ Osteoporosis or Bisphosphonate Use
____Prolonged Bleeding	____Sinus trouble	____ Blood thinners
____HIV positive	____Artificial Joints	____Head or neck injury
____ Smoke or use other forms of tobacco		____Alcoholism or chemical dependency

____Other_____ Date of Last Dental Exam: _____

Allergies to Drugs or Medications: _____

List of Medications: _____

AUTHORIZATION I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. **I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account. In the event of default, I agree to be responsible for all costs of collection including court costs and reasonable attorney's fees.**

X_____ _____

Patient Signature or Parent if Patient is a minor Date