SKYLINE DENTAL, LLC

PATIENT INFORMATION

Name ______________________________ Prefer to go by: ______________ Today's Date ______________

Address ______________________________ City, State & Zip ______________________________

Home Phone ______________ Work Phone ______________ Cell or Message Phone ______________

Date of Birth ______________ Email ______________________________

Marital Status (please check box): Single [ ] , Married [ ] , Widowed [ ] , Divorced [ ] , Other [ ]

CURRENT DENTAL STATUS

Are you currently having any dental problems? No [ ] , Yes [ ]

If 'Yes', please explain ______________________________

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party (guardian) ______________________ Social Security # ______________

(For billing purposes … not necessary if paying in full at time of service)

Address (if different than patient) ______________________________

City, State & Zip

Occupation ______________ Employer ______________ Employer / Work Phone ______________

How would you like to pay for your portion of the provided services? Cash [ ] , Check [ ] , Credit Card [ ] , Other [ ]

RESPONSIBLE PARTY'S SPOUSE

Name of Responsible Party (guardian) ______________________ Social Security # ______________

(For billing purposes … not necessary if paying in full at time of service)

Address (if different than patient) ______________________________

City, State & Zip

Occupation ______________ Employer ______________ Employer / Work Phone ______________

DENTAL INSURANCE

Insurance Company ______________________ Insured Name ______________________

Insured DOB ______________________ Subscriber Number ______________________

Group # ______________ Employer ______________________________

Insurance Co. Address ______________________________

City, State & Zip

Insurance Co. Phone # ______________________

SECONDARY DENTAL INSURANCE

Insurance Company ______________________ Insured Name ______________________

Insured DOB ______________________ Subscriber Number ______________________

Group # ______________ Employer ______________________________

Insurance Co. Address ______________________________

City, State & Zip

Insurance Co. Phone # ______________________

MEDICAL HISTORY

Please keep us updated on any future changes to your medications, allergies or medical history.

General Health: Good [ ] , Fair [ ] , Poor [ ]

Physician's Name ____________________ Last Complete Physical ____________________

Are you currently on any medications? Yes [ ] No [ ]
If 'Yes', please list medications and purpose: ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Are you allergic to any medications? Yes [ ] No [ ]
If 'Yes', please circle or list: ____________________

Penicillin Codeine Latex Local Anesthetics ____________________

Please mark the 'Yes' or 'No' boxes which apply to you and your Medical History:

YES	NO	Medical History	YES	NO	Medical History
		Need antibiotic coverage prior to dental work			Excessive thirst and/or urination
		Artificial joint replacement			Subject to fainting
		Undergone radiation or IV Chemotherapy			Recently hospitalized or past major surgeries
		Use or have used tobacco products in the past			(WOMEN) Currently pregnant? How far?
		Subject to prolonged bleeding			(WOMEN) Currently nursing?

Please mark the 'Yes' or 'No' boxes, if you are *currently, or have ever been diagnosed or treated* for:

YES	NO	Medical History	YES	NO	Medical History	YES	NO	Medical History
		Heart Disease			Ulcers / Colitis			Osteoporosis or other Bony Disease
		Heart Murmur			Acid Reflux			Thyroid Disease
		Congenital Heart Defects			Epilepsy or Seizures			Hives or Skin Rash
		Rheumatic Fever			Anemia			Glaucoma
		Abnormal Blood Pressure			Hemophilia			Long-Term Steroid Treatment
		Stroke			Jaundice or Hepatitis (Type:)			Autoimmune Disorders
		Cancer (Type:)			Kidney Disease or Dialysis			AIDS / HIV
		Tuberculosis or Lung Disease			Asthma or Hay Fever			Drug or Substance Addiction
		Shortness of Breath			Sinus Problems			Eating Disorders (Current or Past)
		Diabetes (Type:)			Chronic or Persistent Cough			Neck or Back Problems

YES	NO	Other
		Do you have any other medical or health condition which is not listed? ____________________
		Is there anything that you prefer to talk to the Doctor in private about?

Notes & Updates: ____________________ Updated: ______ Pt. ______ Staff ______

____________________ Updated: ______ Pt. ______ Staff ______

Payment Agreement: *In the event that this account is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection of sums due and unpaid for the work herein set forth. Delinquent accounts which have to be turned over to a Credit Reporting Collection Agency will have their balances increased 50% to cover the expenses associated with the Collection Agency. In addition to these collection agency expenses, delinquent accounts are also liable for Attorney fees and court costs associated with the collection of the debt.*

Patient or Responsible Party Signature ____________________ Date ____________________