Thank you for selecting us

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Welcome

Patient Information (Confidential)

Date_____

Name _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Email _____ Cell Phone _____

Address _____ City_____ State _____ Zip _____

☐ Male ☐ Female ☐ Receive email & text correspondence

Employer_____ Work Phone _____

How did you hear about us? _____

Person to Contact in Case of Emergency _____Phone _____

Responsible Party (if different from above)

Relationship to Patient_____

Name of Person Responsible for this Account _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Email _____ Cell Phone _____

Address _____ City_____ State _____Zip_____

Employer_____ Work Phone _____

As a courtesy we will submit services rendered to your insurance carrier. Your portion is due in full at time of service. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If you wish to discuss the office's payment policy, please ask us and we will be happy to help.

Dental Insurance Information

Name of Insured_____ Relationship to Patient _____

SS#/SIN _____ Birthdate _____ Date Employed _____

Name of Employer _____ Home/Cell Phone_____

Dental Insurance Company_____ Group # _____Policy/ID# _____

Do you have any additional Dental insurance? ☐Yes ☐No If yes, complete the following

Name of Insured_____ Relationship to Patient _____

SS#/SIN _____ Birthdate _____ Date Employed _____

Name of Employer _____ Home/Cell Phone_____

Dental Insurance Company_____ Group # _____Policy/ID# _____

Continued on the backside

Medical Insurance Information

Name of Insured_____ Relationship to Patient _____

SS#/SIN _____ Birthdate _____ Date Employed _____

Name of Employer _____ Home/Cell Phone _____

Medical Insurance Company _____ Group # _____ Policy/ID# _____

Do you have any additional Medical insurance? ☐ Yes ☐ No If yes, complete the following

Name of Insured_____ Relationship to Patient _____

SS#/SIN _____ Birthdate _____ Date Employed _____

Name of Employer _____ Home/Cell Phone _____

Medical Insurance Company _____ Group # _____ Policy/ID# _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

PRINT NAME	DATE
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN	DATE

PHOTO AGREEMENT

PATIENT RESPONSIBILITIES: Allow Arrowhead Dental to use your before and after photos for social media, educational lectures and informational presentations.

PHOTOGRAPHY RELEASE : I hereby grant permission to the rights of my image without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. By signing this release, I understand this permission signifies that photographs may be used for the following purposes: educational videos, informational presentations, marketing & advertising and electronically displayed via the internet. There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby effective as of the day, month and year first written above.

Patient Sign: _____ Company Sign: _____

Print Name: _____ Print Name: _____

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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Please answer the following questions.

Are you under a physician's care now?	NO	YES	If yes, please explain:
Have you ever been hospitalized or had a major operation?	NO	YES	If yes, please explain:
Have you ever had a serious head or neck injury?	NO	YES	If yes, please explain:
Are you taking any medications, pills, or drugs?	NO	YES	If yes, please explain:
Do you take, or have you taken, Fosamax, Actonel, or Boniva? (Commonly taken for Osteoporosis)	NO	YES	If yes, please explain:
Do you use tobacco?	NO	YES	If yes, please explain:
Do you use controlled substances?	NO	YES	If yes, please explain:
Do you snore or have you been told you snore?	NO	YES	If yes, please explain:
Have you been diagnosed with Sleep Apnea?	NO	YES	If yes, please explain:
Do you wear a C-PAP? or have you in the past? Have you been told to?	NO	YES	If yes, please explain:
Have you had a sleep study or been told to get a sleep study?	NO	YES	If yes, please explain:

Are you **allergic** to the following:		Aspirin		Penicillin		Codeine		Acrylic		Metal		Latex		Local Anesthetics	
	Other If yes, please explain:														

WOMEN: Are you	Pregnant/Trying to get pregnant	NO	YES	Taking oral contraceptives?	NO	YES	Nursing?	NO	YES

Do you have any of the following?

Acid Reflux/GERD		Cortisone Medicine		Heart Trouble/Disease		Recent Weight Loss	
ADD/ADHD		Depression		Hemophilia		Renal Dialysis	
AIDS/HIV Positive		Diabetes		Hepatitis A		Rheumatic Fever	
Alzheimer's Disease		Drug Addiction		Hepatitis B or C		Rheumatism	
Anaphylaxis		Easily Winded		Herpes		Scarlet Fever	
Anemia		Emphysema		High Blood Pressure		Shingles	
Angina		Epilepsy or Seizures		Hives or Rash		Sickle Cell Disease	
Arthritis/Gout		Excessive Bleeding		Hypoglycemia		Sinus Trouble	
Artificial Heart Valve		Excessive Thirst		Irregular Heartbeat		Spina Bifida	
Artificial Joint		Fainting Spells/Dizziness		Kidney Problems		Stomach/Intestinal Disease	
Asthma		Fibromyalgia		Leukemia		Stroke	
Blood Disease		Frequent Cough		Liver Disease		Swelling of Limbs	
Blood Transfusion		Frequent Diarrhea		Low Blood Pressure		Thyroid Disease	
Breathing Problem		Frequent Headaches		Lung Disease		Tonsillitis	
Bruise Easily		Genital Herpes		Mitral Valve Prolapse		Tuberculosis	
Cancer		Glaucoma		Narcolepsy		Tumors or Growths	
Chemotherapy		Hay Fever		Pain in Jaw Joints		Ulcers	
Chest Pains		Headaches		Parathyroid Disease		Venereal Disease	
Cold Sores/Fever Blisters		Heart Attack/Failure		Periodontal Disease		Yellow Jaundice	
Congenital Heart Disorder		Heart Murmur		Psychiatric Care			
Convulsions		Heart Pace Maker		Radiation Treatments			

Have you ever had any serious illness not listed above? ☐ NO ☐ YES If yes, please explain _____

_____

_____