OKUN DENTISTRY

DATE____

NAME____

PREFERRED NAME____________________________________

GENDER: MALE FEMALE

ADDRESS____

____

SINGLE MARRIED DIVORCED OTHER

E-MAIL____

SS#____

DATE OF BIRTH______________________________________

HOME #____

CELL #____

WORK #____

EMPLOYER____

SPOUSE/PARTNER____________________________________

DATE OF BIRTH_______________________________________

EMER. CONTACT_____________________________________

PHONE #____

REFERRED BY:_______________________________________

PLEASE CIRCLE YES OR NO:

Y N CANCER/CHEMO Y N THYROID Y N RADIATION TMENT

Y N EPILEPSY/SEIZURES Y N DIABETES Y N ARITIFICIAL JOINTS

Y N VENERAL DISEASE Y N ASTHMA Y N HIV

Y N HIGH/LOW BLOOD PRESSURE Y N HEART TROUBLE

Y N PSYCHIATRIC PROBLEMS Y N PREGNANT?

Y N DRUG/ALCOHOL ADDICTION: If Yes, Circle - PAST (or) CURRENT

Y N HEPATITIS If Yes, TYPE________________

OTHER MEDICAL ISSUES_______________________________________

CURRENT MEDICATIONS_______________________________________:

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N PENICILLIN Y N LATEX

PLEASE LIST ANY OTHER DRUGS YOU ARE ALLERGIC TO:

____

CHILDREN: CURRENTLY ON FLUORIDATED WATER? Y N

MEDICAL PHYSICIAN_____________________PHONE_______________

WHAT IF ANYTHING WOULD YOU LIKE TO CHANGE ABOUT YOUR SMILE?

____

PLEASE NOTE: A FEE WILL BE CHARGED FOR APPOINTMENTS CANCELLED WITH LESS THAN 24 HOUR NOTICE.

INSURANCE RESPONSIBILITY: DENTAL INSURANCE____________________________________SUBSCRIBER:____________________________

Your dental insurance is based upon a contract between you and/or your employer and an insurance company. If you have questions about your benefits, it is best for you to contact your employer or insurance company directly. Regardless of any dental insurance benefits, the patient(responsible party) is ultimately responsible for all charges. Our office will submit most insurance claims; however, to keep our fees as low as possible, your "ESTIMATED" portion is expected on date of service.

SIGNATURE____ DATE____________________________________

FINANCIAL RESPONSIBILITY:

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my or my child's medical status. I also understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 60 days past due, delinquency at the lesser of the annual rate of 18%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

SIGNATURE____ DATE____________________________________