



Verde Pointe Dental Associates
 Focused on your Dental Care

WELCOME TO OUR OFFICE

PLEASE FILL OUT THIS FORM COMPLETELY

Male Female

NAME _____ BIRTH DATE _____

Married Single Divorced Widowed _____ AGE _____ SS# _____

HOME ADDRESS _____ CITY/STATE _____ ZIP _____ HOME PHONE _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT (If not Patient) _____ RELATIONSHIP _____ PHONE _____

ADDRESS _____ PHONE _____

EMPLOYER _____ PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

PRIMARY DENTAL INSURANCE COMPANY _____ POLICY OR GROUP NUMBER _____

EMPLOYEE'S NAME _____ BIRTH DATE _____ SOCIAL SECURITY NUMBER or I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY _____ POLICY OR GROUP NUMBER _____

EMPLOYEE'S NAME _____ BIRTH DATE _____ SOCIAL SECURITY NUMBER or I.D. # _____

WHO MAY WE THANK FOR INVITING YOU? _____

REASON FOR APPOINTMENT _____

E-MAIL ADDRESS _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES NO

- Heart Problems
- High Blood Pressure
- Heart Murmur
- Heart Valve Replacement
- Liver Disease
- Hepatitis

YES NO

- Kidney Disease
- Diabetes
- Human Immunodeficiency Virus
- Hospitalized within last year
- Cancer or Chemotherapy
- Joint Replacement

YES NO

- Tuberculosis
- Currently Pregnant
- Allergic to Latex
- Allergic to Penicillin
- Allergic to other Medications (List below)

LIST OF MEDICATIONS YOU ARE ALLERGIC TO _____

PLEASE LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING _____

ANY OTHER MEDICAL CONDITIONS THAT WE COULD KNOW ABOUT _____

I hereby authorize any payment of dental benefits to be made directly to Verde Point Dental Associates. I also understand that any amount not covered by my insurance policy is my responsibility and is due at time of treatment. I, the undersigned (patient or legally responsible party) authorize treatment to be rendered and assume financial responsibility. I acknowledge that all noncurrent balances and accounts over sixty days will be charged a service charge of 1.5% per month (18% annually) on the unpaid balance. The cost incurred in collecting this account including court costs, agency fees and attorney fees will be added to your balance due.

My method of payment for today (Please Circle) Check Cash Visa MasterCard

_____ I acknowledge the Notice of Privacy Policies. I understand I may receive a copy upon request.

_____ I understand I may refuse to sign this acknowledgement.

Please Check

Signature of Person Responsible for Account _____ Date _____