

**Patient Information**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Married Single Minor Other  
Last First MI (Preferred Name)

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Email: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ ext \_\_\_\_\_ (Cell): \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip

**Health Information**

Date of Last Dental Visit: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Have you ever had any of the following? Please check all that apply

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS / HIV    | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Sinus Problems     |
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Latex Allergy       | <input type="checkbox"/> Stomach Problems   |
| _____                                  | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Growths            | <input type="checkbox"/> Mental Disorder     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Hay Fever          | <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Head Injuries      | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur       | <input type="checkbox"/> Pregnancy           | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Blood Pressure     | <input type="checkbox"/> Respiratory         | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Dizziness     | Low / High                                  | Problems                                     | <input type="checkbox"/> Other _____        |
|  | <input type="checkbox"/> Jaundice           | <input type="checkbox"/> Rheumatism          | _____                                       |

Do you Smoke or Chew Tobacco? Yes No Amount per day \_\_\_\_\_

Have you ever had any complications following dental treatment? Yes No  
If yes, please explain \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No  
If yes, please explain \_\_\_\_\_

Are you taking any medications, drugs, or pills? Yes No  
If yes, please list \_\_\_\_\_

Have you been told you need to take a pre-medication before dental appointments? Yes No

Are you now under the care of a physician? Yes No  
If yes, please explain \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone: \_\_\_\_\_

In case of emergency, whom may we contact? \_\_\_\_\_ Phone \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment with out fail.

Signature if patient, parent, or guardian \_\_\_\_\_ Date \_\_\_\_\_ Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

**Medical History Update**

Date \_\_\_\_\_ Changes \_\_\_\_\_ Patient Signature \_\_\_\_\_ Reviewed By \_\_\_\_\_

Date \_\_\_\_\_ Changes \_\_\_\_\_ Patient Signature \_\_\_\_\_ Reviewed By \_\_\_\_\_

Date \_\_\_\_\_ Changes \_\_\_\_\_ Patient Signature \_\_\_\_\_ Reviewed By \_\_\_\_\_

**Referral Information**

Whom may we thank for referring you to our practice?

- Another Patient \_\_\_\_\_
- Another Dental Office \_\_\_\_\_
- Other \_\_\_\_\_

## Responsible Party Information

Name: \_\_\_\_\_ Married Single Minor Other  
Last First MI (Preferred Name)

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Email: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ ext \_\_\_\_\_ (Cell): \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip

## Insurance Information

Name of Insured: \_\_\_\_\_ Is Insured a Patient? Yes No

Insured's Birth Date: \_\_\_\_\_ ID# \_\_\_\_\_ Group#: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street Apartment # City State Zip

Insured's Employer Name: \_\_\_\_\_

Insured Employer's Address: \_\_\_\_\_  
Street City State Zip

Patient's Relationship to Insured Self Spouse Child Other \_\_\_\_\_

Insurance Plan Name and Address \_\_\_\_\_

## Authorization for Use or Disclosure of Dental / Health Information

- I have reviewed, understand and agree to the content of the Notice of Privacy.  
 I have reviewed, understand and do not agree to the content of the Notice of Privacy.

Signature of patient, parent or guardian \_\_\_\_\_

Date \_\_\_\_\_

## Consent for Services and Financial Policies

I give permission to Biltmore Dental Center to perform diagnostic, photographic, and therapeutic procedures that may be necessary for proper dental care. I also give permission to Biltmore Dental Center to release my dental and/or medical histories and any other information about my dental treatment to my dental and/or medical insurance companies and other health professionals.

I authorize payment directly to Biltmore Dental Center from my dental insurance benefits that are otherwise payable to me. I understand that my insurance is a contract between me and my insurance company. Biltmore Dental Center cannot accept responsibility for my insurance benefit information and eligibility. Billing my insurance benefit programs is a courtesy to me. Any co-payment is only an estimate. I am ultimately responsible for my balance.

Payment is expected on the day of service unless other arrangements have been made. As payment, we accept: Cash, Check, Bank Debit Card, and Credit Card (Visa, MasterCard, American Express, and Discover).

I understand that my appointment time has been especially reserved for me. If I cannot keep my appointment, I need to give a 24-hour notice. If I am unable to keep my appointment and fail to give a 24-hour notice, I will be charged a cancellation fee of \$50.<sup>00</sup> per appointment hour.

I understand that in the event that my account would need to be assigned to an outside collection agency, a 30% collection fee of the balance will be added to the account.

Signature of patient, parent, or guardian \_\_\_\_\_

Date \_\_\_\_\_

**Thank you for choosing Biltmore Dental Center for your dental health needs. Our mission is to serve our patients with the utmost care and compassion. We aim to provide the highest quality dental care in a relaxed and comfortable atmosphere. We understand you have a choice in dental health care, and we thank you for allowing us to serve you.**