PATIENT'S NAME : _____
(Last) (First) (Middle Initial)

ADDRESS :_____
(City) (State) (Zip Code)

PHONE: _____ // _____ EMAIL _____
(Home) (Cell)

DATE OF BIRTH : _____ SOCIAL SECURTY NUMBER : _____-_____-_____

EMPLOYER _____ EMPLOYER PHONE # _____

Person to Notify in case of emergency (or parent/legal guardian's name and address if different from child's)

NAME / ADDRESS : _____

RELATION: _____ PHONE _____ // ___ _____
(Home) (Cell)

Have you ever had or do you now have any of the following?

Y	N		Y	N		Y	N	
☐	☐	Heart Trouble	☐	☐	Stroke	☐	☐	Have you ever taken Fenfluramine?
☐	☐	Heart Attack (MI)	☐	☐	Epilepsy	☐	☐	and/or Dexfenfluramine (Fen-Phen)?
☐	☐	Rheumatic Fever	☐	☐	Venereal Disease	☐	☐	Are you allergic to Latex?
☐	☐	Heart Murmur	☐	☐	Arthritis	☐	☐	Do you drink alcoholic beverages?
☐	☐	High Blood Pressure	☐	☐	Emotional Problem	☐	☐	Do you smoke or use tobacco?
☐	☐	Emphysema	☐	☐	Psychiatric Treatment	☐	☐	Do you have any allergies?
☐	☐	Tuberculosis	☐	☐	Skin Disease	☐	☐	Are you allergic or sensitive to any medicines?
☐	☐	Asthma	☐	☐	AIDS	☐	☐	Do you now or have you ever taken cortisone?
☐	☐	Diabetes	☐	☐	HIV+	☐	☐	Have you had any difficulty with tooth extractions?
☐	☐	Ulcers	☐	☐	Cancer	☐	☐	Are you taking any medicines now?
☐	☐	Intestinal Trouble	☐	☐	Lupus			*Please List: _____
☐	☐	Hepatitis B	☐	☐	Problems Jaw Joint	☐	☐	Are you currently under the care of a physician?
☐	☐	Hepatitis Other	☐	☐	Bleeding Problems	☐	☐	Have you ever had radiation treatments?
☐	☐	Liver Disease	☐	☐	Sickle Cell Anemia	☐	☐	Women: Are you, or might you, be pregnant?
☐	☐	Kidney or Bladder Disease						

Additional Comments :_____

Referred by:_____ Relative___ Friend ___ Dentist ___ Web ___

Do you like your smile? Y____ N____ **Would you like a whiter smile? Y____ N____**

Reason for today's appointment: _____

What is the most important to you in your dental health? _____

REGARDING PAYMENT: Full payment or your deductible & co-pay (if you are insured) are due on the date of service. We accept cash, check, Visa & MasterCard. You are responsible for the balance of your account whether or not your insurance company pays. Your Insurance policy is a contract between you and your insurance company, we are not party to that contract. ALL OUTSTANDING BALANCES AFTER 90 DAYS (INCLUDING BALANCES OUTSTANDING TO YOUR INSURANCE COMPANY) ARE SUBJECT TO A FINANCE CHARGE EACH MONTH OF 1.5% AND WILL BE TURNED OVER TO A THIRD PARTY COLLECTION AGENCY IF NOT RESOLVED AFTER FINAL NOTICE. YOU WILL BE RESPONSIBLE FOR THE COST OF THE COLLECTION.

***** MISSED APPOINTMENTS:** ***Unless canceled AT LEAST 24 HOURS in advance, our policy is to CHARGE for missed appointments.***

Dental Insurance? Y_____ N_____ I hereby authorize payment of insurance benefits directly to AE Slavsky, DDS, otherwise payable to me.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

To the best of my knowledge the above information is complete and correct. I have read the above information and I understand that I am financially responsible for the charges incurred for services rendered by AE Slavsky, DDS.

_____ _____
Signature (patient, parent or guardian) **Date**