903-657-2266

Dope Family Dental

Welcome!

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ SS#/SIN _____

Address _____ City _____ State _____ Zip Code _____

Email _____ Cell Phone _____ Home Phone _____

Check Appropriate Box: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

If Student, Name of School/College _____ City _____ State _____ Zip _____

Patient or Parent/Gaurdian's Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip Code _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? [ ] Yes [ ] No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

[ ] Cash [ ] Personal Check Credit Card [ ] VISA [ ] MasterCard [ ] I wish to discuss the office's payment policy

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group # _____ Policy ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductable? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCES? [ ] Yes [ ] No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group # _____ Policy ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductable? _____ How much have you used? _____ Max. annual benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1.Are you allergic to or have you had any reaction to the following?	Yes / No			Yes / No
Local Anesthetics (e.g. Novocain)	[ ] [ ]	Sedatives	[ ] [ ]	
Penicillin or any other An	[ ] [ ]	Iodine	[ ] [ ]	
Sulfa Drugs	[ ] [ ]	Aspirin	[ ] [ ]	
Barbiturates	[ ] [ ]	Any Metals (e.g. nick	[ ] [ ]	
Other (Please list)		Latex Rubber	[ ] [ ]	

Turn Over Please