



We are pleased you have selected us to provide dental care for you and your family.

How did you hear about our office? Friend/Family Website Insurance Google Other

Name of family or friend who referred you: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Preferred Name _____ Preferred Pronoun _____ Birthdate _____

Address _____ City/State _____ Zip _____

Mailing address _____

Primary Contact Phone _____ Home / Cell / Work (please circle one)

Secondary Contact Phone _____ Home / Cell / Work (please circle one)

May we leave a message at home or on voicemail? YES/NO

Email address _____ SSN _____

Employer _____

Spouse/Partner Name _____ Phone # _____

Emergency Contact _____ Phone # _____

Nearest relative not living with you _____ Phone # _____

RESPONSIBLE PARTY (If under 18 years of age)

Name of Person Responsible for Account _____ Relationship to Patient _____

Address _____ City/State _____ Zip _____

Phone# _____ SSN _____ Birthdate _____

INSURANCE INFORMATION

Subscriber/Insured's Name _____ Social Sec.# _____

Subscriber/Insured's Employer _____ Birthdate _____

Insurance Company _____ Group# _____

Insurance Company Address _____ Subsc.ID# _____

Do you have secondary insurance? YES / NO

(more on other side)

MEDICAL INFORMATION

Have you been hospitalized or under the care of a medical doctor in the last 2 years? (Other than routine)	YES / NO
Are you currently taking any medications? If so please list: _____ _____	YES / NO
Have you ever taken bisphosphonates or other meds for Osteoporosis?	YES/ NO
Are you sensitive or allergic to any medications? If so, please list: _____	YES / NO
Have you used or do you currently use tobacco, marijuana or vape? How Often? _____	YES / NO
Have you had a COVID 19 Vaccine?	YES / NO

Please circle to indicate which of the following you have had or have at the present.

Allergies or Hives	Allergy to Latex/ Metals	Anemia	Angina Pectoris
Anxiety/ Depression	Arthritis	Artificial Heart Valve	Artificial Joints
Asthma	Auto Immune Disorder	Cancer Chemotherapy	Cold Sores
COVID 19	Diabetes I/II	HIV positive / AIDS	Epilepsy / Seizures
Fainting / Dizziness	Crohn's	Heart Attack	Heart Disease
Heart Murmur	Heart Surgery	Hepatitis A B C	High Blood pressure
Kidney Trouble	High Cholesterol	Mitral Valve Prolapse	Osteoporosis
Liver Disease	Pacemaker	Radiation Therapy	Rheumatic Fever
Stroke	Substance Abuse	Thyroid problems	

Do you have or have you had any disease, condition or problem not listed? If so, please list: _____ _____	YES / NO
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For Women only:

Are you pregnant? YES / NO	Are you nursing? YES / NO	Taking birth control pills? YES / NO
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I understand the above information is necessary to provide me with dental care in a safe and efficient manner.

I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

You and/or your assignees are hereby authorized to contact me at any telephone number, including cell numbers and email address provided by me or otherwise obtained by you, using text, email and to leave messages on such devices.

I authorize treatment of the person named above and agree to accept full responsibility for payment regardless of any third party responsibility. I hereby authorize my Provider's office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper medical care. I authorize the release of any medical information requested by my insurance company. I authorize payment of benefits directly to my Provider's office. Finance charges may be charged to balances over 60 days at the rate of 9% per annum. If my account becomes past due, I/we agree to pay all attorney fees, court costs, filing fees and process service fees which may be assessed by any collection agency or law firm retained to pursue the matter and for the venue and jurisdiction to be in Whatcom County.

I certify that all the above information is correct and I have read, understand and agree to the above statements.

Patient or Responsible Party Signature:

_____ Date: _____

Office use only: _____