EMIL M. VERBAN JR. D.D.S.

Your full name, Mr., Mrs., Miss., Ms. _____

Age _____ Birthdate _____ Person responsible for account _____

Residence Address _____ City _____ Zip _____ Phone _____

Employed by _____ Occupation _____

Business Address _____ City _____ Zip _____ Phone _____

Single _____ Married/Spouse name _____ Social Security # _____

If married, occupation of spouse _____ Employed by _____

Business Address _____ City _____ Zip _____ Phone _____

Dental Insurance information: Insurance Co. _____ Group # _____

Employer (Co. Name, address and phone) _____

_____

_____

Member Name _____ Member SSN _____ Member Date of Birth _____

Patient's relationship to Member: Self / Spouse / Child / Other (circle one)

In order to show our appreciation, whom may we thank for referring you to our office _____

		Yes	No
1.	Have you had any disease, illness, surgeries, perm disabilities or concerns in the past 2 years?	❑	❑
	If yes, for what: _____		
2.	Is a premedication required by your doctor for dental appointments?	❑	❑
	If yes, for what reason: _____		
3.	Are you taking any medication (vitamins, medicines or drugs) at the present time?	❑	❑
	If yes, explain: _____		
4.	Are you aware of being allergic to an anesthetic, antibiotic, or any other drug?	❑	❑
	_____		
5.	Do you have or have you had any of the following diseases or problems:		
	a. Rheumatic fever or rheumatic heart disease	YES	NO
	b. Congenital heart lesions	YES	NO
	c. Cardiovascular disease (heart trouble, heart attack, high blood pressure, arteriosclerosis, stroke)	YES	NO
	d. Diabetes	YES	NO
	e. Hepatitis, jaundice or liver disease	YES	NO
	f. Arthritis	YES	NO
	g. Kidney trouble	YES	NO
	h. Tuberculosis	YES	NO
	i. Venereal disease	YES	NO
6.	Do you have any blood disorder such as anemia or hemophilia	YES	NO
7.	Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips	YES	NO
8.	(Women) Are you pregnant	YES	NO

_____ _____

Signature of Patient Date

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME

Date _____ Signed _____