TAUNTON COSMETIC DENTISTRY PATIENT FORM

Last Name	First Name	Middle Initial	SSN:	Date of Birth / /
Home Address:				Home Phone: ( )
City:	State:	ZIP Code:		Cell Phone: ( )
Work Address and Company Name:				Work Phone: ( )
Dental Insurance:	Subscriber Number:	Group Number:		Patient Email:
Last Name of Subscriber:	**First Name:**	Date of Birth: / /		Relationship:
Emergency Contact:	Relationship to Patient:	Cell Phone ( )		Work Phone : ( )

MEDICAL INFORMATION

Name of Physician:	Address:		Date of last physical: / /
Allergies 1)	Medications 1)	3)	Are you pregnant? ❑Yes ❑No
2)	2)	4)	Do you smoke? ❑Yes ❑No

Conditions	YES	NO		YES	NO		YES	NO		YES	NO
Stroke			Arthritis			AIDS			Tuberculosis		
Heart disease			Anemia			Diabetes			Cancer		
Rheumatic fever			Heart murmur			Asthma			Hepatitis		
High blood pressure			Bleeding disorder			Epilepsy			Other		

Have you ever had any surgeries? If yes, please list:

DENTAL CONCERNS

	YES	NO		YES	NO		YES	NO
Do you like your smile?			Want to improve your smile?			Sensitivity		
Do you want whiter teeth?			Want to improve your dental health?			Bleeding gums		

I acknowledge receipt of the privacy practices notice.

I consent to receiving the treatment recommended to me by the doctor / staff.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Taunton Cosmetic Dentistry or the insurance company to release any information required to process my claims.

We require at least 24 business hours' notice for any cancellation. There will be a $50 fee for any appointment canceled without proper notice.

Patient/Guardian signature Date

Doctor/Staff signature Date