INTRODUCTORY QUESTIONNAIRE

In order to render an optimum health service it is necessary to obtain a variety of vital personal information which will be kept confidential.

PATIENT INFORMATION: Date_____

Patient_____ Home Phone_____

Address_____ Work Phone_____

_____ Cell Phone_____

City State Zip

Best Time To Reach You_____

E Mail Address_____

Sex:__M__F Age____ Birthdate_____SS#_____

Single__Married__Widow__Divorced__Separated__

Spouse_____

Employer_____

Emp.
Address_____

Responsible For Account If Not Patient:

Name and Address_____

_____

_____

Phone If Different from Patient_____

DENTAL INSURANCE:

Primary Insurance Holder_____

Relationship To Patient_____Birthdate_____SS#_____

Insurance Company_____

Insurance Address_____

Group#_____

I, the undersigned certify that I(or my dependent)have insurance coverage with _____and assign directly to Dr. Derrick all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

PERSON TO CONTACT FOR EMERGENCY_____

Relationship_____Phone Number_____

To Whom May We Thank for Referring You To Our Office_____

Additional Information That You Would Like Us To Know Concerning The Patient.

_____

_____

Assignment And Release:
I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge may be added to my account.

Patient_____Date_____

Patient or Responsible Party_____Relationship To Patient_____