



650 East Main Street, New Holland, PA • 717-354-3200 • e-mail: info@drdanwest.com

Date: _____

1.1P

Patient: () First Name _____ M.I. _____ Last Name _____ Nickname _____
 Sex: Male Female Date of Birth _____ Age _____ Soc. Sec.# _____ Email _____
 Street _____ City _____ State _____ Zip _____
 Home Tel.# () _____ Business Tel.# () _____ Ext. _____ Employer _____
 Cell Phone # () _____ Medical Doctor _____ Referred By _____
 Driver's Lic. # _____ Nearest relative not living with you _____ Tel. # () _____
 Have you ever been a patient of our practice? Yes No Method of Personal Payment: Cash Check Credit Card

Who will be responsible for your account? (If self, skip to next paragraph) Self Spouse Father Mother Other _____
 Name _____ Soc. Sec.# _____ Home Tel. () _____
 Street _____ City _____ State _____ Zip _____
 Employer _____ Tel. () _____

Spouse or other guarantor information (if different from above)
 Name _____ Relation _____ Soc. Sec.# _____ Home Tel. () _____
 Street _____ City _____ State _____ Zip _____
 Employer _____ Tel. () _____

1.10

INSURANCE INFORMATION

Patient: Student: Full Time Part Time Not School Name/Address _____
 Married Divorced Legally Separated Widow Single _____
 Employed: Full Time Part Time Retired Not _____

1.11

PRIMARY DENTAL INSURANCE COMPANY

Employer _____
 Business Address _____
 Business Telephone Number () _____ Plan _____

Insurance Company Name _____
 Address _____ Telephone Number () _____

Group Number _____ **Group Name** _____
 Insured Party _____ Relation _____
 Sex: Male Female Date of Birth _____
 Street _____
 City, State, Zip _____
 Telephone Number () _____ Social Security Number _____
 I.D. Number _____

MEDICATION

ARE YOU NOW TAKING....	Yes	No	Notes	ARE YOU NOW TAKING....	Yes	No	Notes
201. Any kind of medicine, drugs, or pills?				205. Any kind of natural product, herbal supplement, or homeopathic remedy?			
202. Blood Thinners (i.e. Coumadin, Aspirin, Advil)?				206. Please list any other medications you are taking:			
203. Have you ever taken diet pills?							
204. Tranquilizers?							

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes	ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes
207. Local anesthetics?				213. Other medications?			
208. Penicillin?				214. Latex?			
209. Other antibiotics?				215. Soy?			
210. Sodium pentothal, Valium, or other Tranquilizers?				216. Eggs / Yolk?			
211. Aspirin?				217. Sulfides?			
212. Codeine or other narcotics?				218. Please list any allergies other than drug allergies:			

WOMEN

219. Is there a possibility of pregnancy?				220. Are you taking birth control pills?			
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WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD?

Do you wish to speak to the doctor privately about anything? **Yes** **No**

IN CASE OF EMERGENCY, CONTACT: Name _____

Tel # H () _____

Wk # () _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: **X**
(Parent or Guardian if minor) _____

Reviewed by: **X** _____

Date: **X** _____

Release:

I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

Signature of patient: *(Parent or Guardian if minor)* **X** _____

Date: **X** _____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* **X** _____

Date: **X** _____

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* **X** _____

Date: **X** _____