Discovery Dental Centers

Last Name _____ First Name_____ MI_____
Address_____ City_____ State____ Zip_____
Birthdate _____ Soc. Sec. Number _____ Marital Status_____
Home Phone #_____ Sex_____
Employed by_____ Work Phone_____ Cell Phone_____
Spouse's Name_____ DOB_____ Soc. Sec. Number_____
Employed by_____ Work Phone_____ Cell Phone_____
Is it ok to correspond with you through text? ☐ Yes ☐ No Email address_____
Dental Insurance_____ Secondary Insurance_____
Name of Medical Doctor_____ Phone_____
Who is financially responsible for this bill?_____
Payment is expected at the time the dental services are rendered.
Please check method of payment: Charge Card ☐ Check ☐ Cash ☐
Whom may we thank for referring to us? _____
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	Yes	No		Yes	No
Heart Disease/Failure/Attack	☐	☐	Asthma	☐	☐
Angina Pectoris	☐	☐	Bruise Easily	☐	☐
Congenital Heart Disease	☐	☐	Seasonal Allergies/Hives	☐	☐
Heart Murmur	☐	☐	Sinus Trouble	☐	☐
High Blood Pressure/Arteriosclerosis	☐	☐	Radiation/Chemotherapy	☐	☐
Mitral Valve Prolapse	☐	☐	Hepatitis A(infectious)/B (serum)	☐	☐
Artificial Heart Valve/Pacemaker	☐	☐	Venereal Disease	☐	☐
Heart Surgery	☐	☐	AIDS/HIV positive	☐	☐
Rheumatic Fever	☐	☐	Blood Transfusion	☐	☐
Arthritis/Rheumatism	☐	☐	Hemophilia/Anemia	☐	☐
Drug Addiction	☐	☐	Sickle Cell Disease	☐	☐
Stroke	☐	☐	Liver Disease	☐	☐
Artificial Joints	☐	☐	Epilepsy or Seizures	☐	☐
Kidney Trouble	☐	☐	Psychiatric Treatment	☐	☐
Diabetes	☐	☐	Allergy to any Medications	☐	☐
Thyroid Problems	☐	☐	Please specify_____		
Glaucoma	☐	☐	_____		
Emphysema	☐	☐	Current Medications	☐	☐
Chronic Cough	☐	☐	Please specify_____		
Tuberculosis	☐	☐	_____		

WOMEN: Are you pregnant or taking birth control pills? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are true. If I ever have a change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

The undersigned hereby authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature here authorizes my dentist to submit claims for benefits, services rendered, or to be rendered without obtaining my signature. This holds true for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____

Authorized Signature of Covered Person/Employee **Date**

_____ I acknowledge that I will be personally responsible for any and all charges not covered by my insurance.