Comfort Dental Care

Welcome to our office

Patient Information

Date:_____ Home Phone( )_____ Cell Phone( )_____

Patient Name: _____ Social Security #: _____
Last Name First Name

Address:_____ Email _____

City: _____ State:_____ Zip:_____ Sex ❑ M ❑F

Age:_____ Birth Date:_____ ❑ Married ❑ Single ❑ Minor

Patient Employer/School:_____ Occupation:_____

Employer/School Address:_____ Phone:_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____Phone:_____

Primary Insurance

Person responsible for account:_____
Last Name First Name Middle Initial

Relationship to patient: ▫ Self ▫ Spouse ▫ Parent ▫ Other _____ Birth Date:_____

Social Security #: _____

Address (if different from patients)_____ Phone ( ) _____

City:_____ State:_____ Zip:)_____

Person Responsible employed by:_____ Occupation:_____

Insurance Company:_____ Phone ( ) _____

Subscriber #_____ Group#_____ Contract #_____

Additional Insurance

Is patient covered by another insurance plan? ▫ Yes ▫ No

Subscribers Name:_____ Birth Date:_____

Relationship to patient: ▫ Self ▫ Spouse ▫ Parent ▫ Other _____ Social Security #: _____

Address (if different from patients)_____ Phone ( ) _____

City:_____ State:_____ Zip:_____

Subscriber employed by:_____ Occupation:_____

Insurance Company:_____ Phone ( ) _____

Subscriber #_____ Group#_____ Contract #_____

Patient Name:_____ Date:_____

Dental History/Expectations

What would you like to discuss with the dentist today?

❑ Tooth Ache ❑ Removal of wisdom teeth ❑ Braces
❑ Gum Problem ❑ Replace missing teeth ❑ Other_____
❑ Routine check-up ❑ Cosmetic Dentistry

Do you have any missing teeth? ❑ Yes ❑ No If yes, do you wear an appliance? ❑ Yes ❑ No Year Made:_____

Are you pleased with the appearance of your smile? ❑ Yes ❑ No Explain:_____

Date of last dental exam:_____ Date of last dental x-rays:_____

Medical History

Physicians name:_____ Date of last visit:_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?". ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, please describe_____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, please describe_____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Have you ever had an allergic reaction to local anesthetic? ❑ Yes ❑ No Allergy to latex? ❑ Yes ❑ No

Check (✓) if you have had problems with any of the following:

❑ Anemia	❑ Cortisone Treatments	❑ Hepatitis	❑ Scarlet Fever
❑ Arthritis,Rheumatism	❑ Cough, persistent	❑ High Blood Pressure	❑ Shortness of Breath
❑ Artificial Heart Valve	❑ Cough up Blood	❑ HIV/AIDS	❑ Skin Rash
❑ Artificial Joints	❑ Diabetes	❑ Jaw Pain	❑ Stroke
❑ Asthma	❑ Epilepsy	❑ Kidney Disease	❑ Swelling of feet/ankles
❑ Back Problems	❑ Fainting	❑ Liver Disease	❑ Thyroid Problems
❑ Blood Disease	❑ Glaucoma	❑ Mitral Valve Prolapse	❑ Tobacco Habit
❑ Cancer	❑ Headaches	❑ Pacemaker	❑ Tonsilitis
❑ Chemical Dependency	❑ Heart Murmur	❑ Radiation Treatment	❑ Tuberculosis
❑ Chemotherapy	❑ Heart Problems	❑ Respiratory Disease	❑ Ulcer
❑ Circulatory Problems	❑ Hemophilia	❑ Rheumatic Fever	❑ Venereal Disease

Medications
List medications you are currently taking

_____

_____

Allergies

_____

_____

Authorization

I certify that I, and/or my dependant(s), have insurance coverage with _____and assign directly to Gurrinder S. Atwal DDS, 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. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

In consideration for the professional services rendered to me, or at my request, by Dr. Atwal, I agree to pay therefore the reasonable value of said services to Dr. Atwal, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I grant my permission to you or your assignee, to telephone me at home, at my work or on my cellular phone to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian