Bolt Dental

New Patient Information

Today's Date__________________ email address:____________________________________

Name(First)____(Last)____________________________ _______(MI)___Address____City____________________ __________State____Zip_______

Date of Birth________________________ Soc. Sec. #_____________________________Drivers License #____________

Check Box: □Male □Female □Minor □Married □Single □Divorced □Widowed □Separated □Other

Phone (Home):__________________________(Work) __________________(Ext):______ (Cell):_____________________

Patient or Parent Employer____

Business Address__________________________________ City___________________State____Zip_________________

Person To Contact In case of Emergency ____

Home Phone ___________________ Work Phone _______________________ Cell Phone__________________________

For your convenience, we offer the following methods of payment. Please check which form you prefer. PAYMENT IN FULL FOR A SERVICE IS EXPECTED AT EACH APPOINTMENT. □Cash □Personal Check □Credit Card □Care Credit

Insurance Information

Name of insured____ Relationship to patient_______________________

Birthdate____________________ Soc Sec # __________________________ Date employed________________________

Name of employer____ Work Phone____________________

Address of Employer____ City_______________State_____ Zip________

Insurance Co. ______________________________ Group #_______________________ Policy ID #__________________

Ins. Co. Address____________________________________ City________________________
State_____Zip__________

Do you have additional insurance? ▫YES ▫NO

Name of insured____ Relationship to patient______________________

Birthdate____________________ Soc Sec # __________________________ Date employed________________________

Name of employer____ Work Phone____________________

Address of Employer____
City_______________State_____ Zip________

Insurance Co. ______________________________ Group #_______________________ Policy ID #__________________

Ins. Co. Address____________________________________ City________________________
State_____Zip__________

Patient Health History (Please check all that apply)

□AIDS/HIV ▫Anemia ▫Arthritis

▫Artificial Joint ▫Artificial Heart Valve ▫Asthma

▫Blood Disease ▫Cancer ▫Chemical Dependency

▫Diabetes ▫Epilepsy ▫Excessive Bleeding

▫Heart Disease ▫Heart Murmur ▫Hepatitis, Jaundice, Liver Disease

▫High Blood Pressure ▫Mental Disorders ▫Nervous Disorders

▫Osteoporsis ▫Pacemaker ▫Radiation Treatment

▫Respiratory Disease ▫Rheumatic Fever ▫Sinus Problems

▫Stroke ▫Tuberculosis ▫Tumor

▫Ulcer ▫Venereal Disease ▫Other: _______________________

Have you ever had any allergic response to any drug? Please list
____

____
_____________.

Are you under medical treatment now? If yes, please explain ___________________________________

____ ____________.

Have you taken any medications for Osteoporosis in the last year? If so, what medications have you taken?

____ _____.

Are you taking drugs or medications at this time? If so, please list _______________________________

____ ____________.

Have you had any major operations? Describe ____.

Are you in general good health at this time? ____.

Is there any other information that should be known about your health or previous dental visits?

____ ____________.

Name of physician(s) ____ Phone _________________________

Name of previous dentist _______________________________________ Phone _________________________

I certify that I have read and answered the above questions to the best of my knowledge. I understand providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to me or my child during the period of such dental care to third party payors and/or health practitioners and/or compilation for research. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.
X____