BALMORAL DENTAL CENTER

BDC A Stunning Smile for Much Less.

4000 Balmoral Dr, Suite 201, Huntsville, AL 35801 (256)429-3870

WELCOME TO OUR PRACTICE!!

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Prefer to be called _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Ph # _____ Cell Ph # _____ Work Ph # _____

Email _____ Do you prefer? Email __ Call __Text __ Any__

Sex: M __ F __ Marital Status: Minor __ Single __ Married __ Divorced __ Widowed __

In case of emergency, who should we contact? _____ Ph # _____

ACCOUNT AND INSURANCE INFORMATION

Person responsible for Account:

Name _____ Relationship _____ Soc. Sec. # _____

Address _____

Home Ph # _____ Work Ph # _____ Cell Ph # _____

Employer _____ Occupation _____

Insurance Company _____ Policy Holder _____

PLEASE PROVIDE YOUR INSURANCE CARD SO THAT WE MAY MAKE A PHOTOCOPY

How did you hear about us? _____

Whom may we thank for referring you to our practice? _____

Are there any other members of your family that we need to schedule appointments for? Yes __ No __

PLEASE COMPLETE BOTH SIDES

DENTAL HISTORY

Former Dentist _____ Date of Last Dental Visit _____
Please check all that apply:

Bad Breath……..__	Loose Teeth or Broken Fillings……..__	Sensitivity to Sweets…….__
Bleeding Gums……..__	Orthodontic Treatment……..__	Gag easily……..__
Blisters on Lips or Mouth…__	Pain Around Ear……__	Frequent Headaches……..__
Grinding Teeth……..__	Periodontal Treatment……__	Jaw, Head or Neck Injuries……__
Tooth Pain……..__	Sensitivity to Cold __ Hot__ Biting __	Jaw Difficulty: Clicking__ Pain__

Have you ever had any serious problems associated with previous dental treatment? Yes __ No __
Please add anything you feel is important _____
Reason for your visit today _____

MEDICAL HISTORY

General Health: Excellent __ Good __ Fair __ Poor __ Date of Last Medical Checkup _____
Physicians Name _____ Ph # _____
Pharmacy Name _____ Ph# _____
Are you allergic to Penicillin __ Codeine __ Sulfa drugs __ Erythromycin __ Local Anesthetics __
Any other allergies _____
Are You Currently Taking Any Medications? Yes __ No__ Please List _____
_____
Have you been treated for or currently have:
AIDS __ Anemia __ Arthritis __ Artificial Joints __ Asthma __ Cancer __ Diabetes __ Epilepsy __
Headaches __ Heart Problems __ HIV __ HBP __ Herpes __ Hepatitis__(Type __) Jaundice __
Kidney Disease __ Latex Sensitivity __ Mitral Valve Prolapse __ Nervous Problems __ Pacemaker __
Psychiatric Care __ Radiation Treatment __ Rheumatic Fever __ Scarlet Fever __ Shortness of Breath __
Sinus Trouble __ Stroke __ Thyroid Problems __ Tonsillitis __ Tuberculosis __ Ulcer __
Please add anything you feel is important _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to **BALMORAL DENTAL CENTER** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the Dentist and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

THANK YOU FOR CHOOSING BDC TO ASSIST YOU WITH YOUR STUNNING SMILE!!