

# salling & tate

## general dentistry

### PERSONAL INFORMATION

Patient's Name \_\_\_\_\_ Name that you wished to be called \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_  
 Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_  
 Is Patient a College Student? \_\_\_\_\_ If yes, where do you attend school \_\_\_\_\_  
 Are you F/T or P/T \_\_\_\_\_ (Please present your student ID to our receptionist if filing for Insurance)  
 Name of Spouse (or Parent) \_\_\_\_\_  
 RESIDENCE Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_  
 Patient's Occupation \_\_\_\_\_ Employed by \_\_\_\_\_  
 Spouse or Parent's Occupation \_\_\_\_\_ Employed by \_\_\_\_\_  
 Who may we thank for referring you to our office \_\_\_\_\_  
 Purpose of today's visit: \_\_\_\_\_  
 How will you be paying for your visits: Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_ CareCredit \_\_\_\_\_

### INSURANCE INFORMATION

Do you have dental insurance? Yes \_\_\_\_\_ No \_\_\_\_\_  
 (IF YOU HAVE DENTAL INSURANCE PLEASE COMPLETE THE BACK OF THIS FORM)

### MEDICAL HISTORY

Date of last Dental exam \_\_\_\_\_ Where X-Rays taken? Yes No  
 Date of last Medical Exam \_\_\_\_\_ Name of Medical Doctor \_\_\_\_\_  
 Do you have any **allergies**? Yes No If yes, please list the allergy and the reaction: \_\_\_\_\_  
 \_\_\_\_\_  
 Are you currently taking any **medications**? Yes No If so, please list the medication: \_\_\_\_\_  
 \_\_\_\_\_

*Do you have, or have you ever had, any of the following? Please Circle Yes or No:*

Heart (Surgery, Disease, Attack).. Yes No	Latex Sensitivity.....Yes No	Sickle Cell Disease.....Yes No
Chest Pain.....Yes No	Chemotherapy.....Yes No	Bruise Easily.....Yes No
Heart Murmur.....Yes No	Radiation Therapy.....Yes No	Neurological Disorders.....Yes No
Rheumatic Fever.....Yes No	Tuberculosis.....Yes No	Sinus Trouble.....Yes No
Mitral Valve Prolapse.....Yes No	Chronic Cough.....Yes No	Hay Fever.....Yes No
Artificial Heart Valve.....Yes No	Emphysema.....Yes No	Cortisone Medicine.....Yes No
Heart Pacemaker.....Yes No	Asthma.....Yes No	Swollen Ankles.....Yes No
High Blood Pressure.....Yes No	AIDS/ HIV.....Yes No	Arthritis/Rheumatism.....Yes No
Congenital Heart Disease.....Yes No	Cold Sores/ Fever Blister...Yes No	Contact Lens.....Yes No
Artificial Joints (hip, knee, ect)....Yes No	Hemophilia.....Yes No	Glaucoma.....Yes No
Hepatitis.....Yes No	Redux/Phen-Fen diet pills...Yes No	Thyroid Problems.....Yes No
Blood Transfusion.....Yes No	Diabetes.....Yes No	Yellow Jaundice.....Yes No
Epilepsy or Seizures.....Yes No	Stroke.....Yes No	Ulcers.....Yes No
Liver Disease.....Yes No	Fainting or Dizzy Spells.....Yes No	Kidney Trouble.....Yes No
Psychiatric/Psychological Care.....Yes No	Birth Control Pills.....Yes No	

**Woman:** Are you currently or possibly pregnant? Yes No

I have filled out my medical history to the best of my ability. I understand that I am responsible for any charges incurred in this office on the day of service unless other arrangements have previously been made with Amy Russell (Office Manager). I authorize the release of my past medical and/or dental history, including payment history, to Drs. Salling & Tate, PLLC.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Are you able to see any dentist you choose or do you have to pick from a list of dentists? \_\_\_\_\_  
(In or out of network? Drs. Salling & Tate are out of network.)

Patient's Name \_\_\_\_\_ PT SS# \_\_\_\_\_ PT DOB \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Insured Employee's Name \_\_\_\_\_ EMP SS# \_\_\_\_\_ EMP DOB \_\_\_\_\_  
(If different from above)  
EMPLOYER PROVIDING INSURANCE \_\_\_\_\_  
INSURANCE COMPANY NAME \_\_\_\_\_  
INSURANCE COMPANY ADDRESS \_\_\_\_\_  
GROUP # \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_  
EFFECTIVE DATE OF COVERAGE \_\_\_\_\_ YEARLY MAXIMUM \_\_\_\_\_  
IS THIS PER CALENDAR YEAR? \_\_\_\_\_ IF NOT, WHAT IS THE INS YEAR \_\_\_\_\_  
DEDUCTIBLE \_\_\_\_\_ DOES THE DEDUCTIBLE APPLY TO PREVENTIVE SERVICES? \_\_\_\_\_  
COVERAGE: PREVENTIVE \_\_\_\_\_ % BASIC \_\_\_\_\_ % MAJOR \_\_\_\_\_ %  
IS THERE A WAITING PERIOD ON ANY SERVICES? \_\_\_\_\_ IF SO, WHAT IS IT \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insured Employee's Name \_\_\_\_\_ EMP SS# \_\_\_\_\_ EMP DOB \_\_\_\_\_  
EMPLOYER PROVIDING INSURANCE \_\_\_\_\_  
INSURANCE COMPANY NAME \_\_\_\_\_  
INSURANCE COMPANY ADDRESS \_\_\_\_\_  
GROUP # \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_  
EFFECTIVE DATE OF COVERAGE \_\_\_\_\_ YEARLY MAXIMUM \_\_\_\_\_  
IS THIS PER CALENDAR YEAR? \_\_\_\_\_ IF NOT, WHAT IS THE INS YEAR \_\_\_\_\_  
DEDUCTIBLE \_\_\_\_\_ DOES THE DEDUCTIBLE APPLY TO PREVENTIVE SERVICES? \_\_\_\_\_  
COVERAGE: PREVENTIVE \_\_\_\_\_ % BASIC \_\_\_\_\_ % MAJOR \_\_\_\_\_ %  
IS THERE A WAITING PERIOD ON ANY SERVICES? \_\_\_\_\_ IF SO, WHAT IS IT \_\_\_\_\_

**PLEASE NOTE:**

**You are responsible for the entire cost of your dental treatment at each visit. We will ESTIMATE your co-payment for each visit and you will need to pay this amount on the day of service. As a courtesy to you, we will file a claim to your insurance company on your behalf. If YOUR insurance company does not pay or pays less than is estimated, the remaining balance becomes due and is your immediate responsibility. Any balance remaining on your account 90 days following the date of service will incur finance charges of 18% per annum.**

**FOR ALL CLAIMS TO BE FILED BY DRS. SALLING & TATE, PLLC:**

If you cannot provide us with the above insurance information, you will need to pay in full at the time of service. We can give you the necessary paperwork to file with your dental insurance.

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**I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION REQUIRED BY MY INSURANCE COMPANY TO FILE A CLAIM FOR PAYMENT ON MY BEHALF.**

**I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO DRS. SALLING & TATE, PLLC.**

\_\_\_\_\_  
SIGNED (Patient or parent of minor)      Date

\_\_\_\_\_  
SIGNED (Insured Person)      Date

