VIENNA COSMETIC & FAMILY DENTISTRY

New Patient Information **Today's Date**_____

Name_____ Occupation_____
Date of Birth_____ Employer_____
Address_____ Employer Address_____
City/State/Zip_____ City/State/Zip_____
SSN_____ Employer Phone_____
Home Phone_____ Emergency Contact_____
Cell Phone_____ Emergency Phone_____
Email_____ Emergency Address_____
Best way to contact_____ City/State/Zip_____

Dental Insurance

Primary Insurance_____ Secondary Insurance_____
Subscriber Name_____ Subscriber Name_____
Address_____ Address_____
City/State/Zip_____ City/State/Zip_____
Date of Birth_____ Date of Birth_____
Subscriber SSN_____ Subscriber SSN_____
Insurance Group #_____ Insurance Group #_____
Ins. Address_____ Ins Address_____
City/State/Zip_____ City/State/Zip_____

Health Information

Please indicate the following if you have a history or have presently by checking the corresponding box:

□ Heart Attack or Stroke	□ Kidney or Liver problems	□ Anemia or Sickle Cell Disease
□ Heart Disease or angina	□ Ulcers	□ Bruise easily
□ Heart pacemaker	□ Thyroid problems	□ Radiation or chemotherapy
□ Heart surgery/artificial valve	□ Glaucoma	□ Sinus Trouble
□ High Blood Pressure	□ Asthma or emphysema	□ Epilepsy or seizures
□ Artificial joints (hip, knee…)	□ Hepatitis B C or D	□ Nervousness
□ Arthritis or steroid medication	□ Venereal Disease	□ Psychiatric Treatment
□ Diabetes	□ HIV or AIDS	□ Substance abuse or addiction
□ Tuberculosis	□ Blood Transfusion	□ Allergies or hives (non-seasonal)
□ Fainting or dizzy spells	□ Hemophilia	□ Cancer (of any type)
□ Currently Pregnant or Nursing	□ Bleeding disorders	□ Other_____

□ Congenital Heart Disease, Heart Murmur, Mitral Valve Prolapse or history of Rheumatic Fever

Current Medications_____
_____

Physician Name_____ Physician Address_____
Physician Phone_____ City/State/Zip_____

VCF VIENNA COSMETIC & FAMILY DENTISTRY

Allow us to get to know you and give you care catered toward your needs and goals

Do you have any Dental Concerns _____

What do you expect from our office_____

Are you in any pain, if yes where_____

When was you last dental visit_____Last X-rays_____

Do grind or clench your teeth_____

Do you Snore_____

Are you satisfied with the appearance of your smile_____

Do you have any concerns with your teeth_____

Do you want whiter teeth_____

Do you floss_____ How often_____

Do your gums bleed when your brush_____

Do you smoke_____ How often_____

Please list any Drug or Latex Allergies_____

Whom may we thank for referring you_____

FINANCIAL INFORMATION

Full payment is expected at the time of service. As a courtesy, Vienna Cosmetic and Family Dentistry will file your insurance claim electronically for you with your primary carrier. We will do our best to provide you with an accurate ***estimate*** of your plan benefit; however**,** the patient is responsible for knowing all co-pay, deductible and maximum benefit information prior to all visits.

I understand that it is often necessary to take x-rays, study models, photographs or other diagnostic aids deems appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I understand there are certain risks involved with anesthetics and that many dental procedures and surgical procedures carry risks that can permanently cause damage to the patient.

I also understand that payment of my bill is my legal obligation. All filing of insurance and confirmation of insurance payments to be made by my insurance company are my sole responsibility. Any assistance concerning these matters granted by this office is strictly given as a courtesy and implies no responsibility on their part for filing, follow-through or confirmation. If this account is placed with an attorney or collection agency, I agree to pay attorney fees of 40% of the unpaid principal and interest owing, plus all court costs and interest in the amount of 1.5% per month beginning 60 days after the account as become due. I further agree to pay return check charges of $25 per returned check. A $50 fee will apply for cancellations within 48 hour of an appointment. I understand that all the above confidential information is true and correct to the best of my knowledge and will help provide the best dental care for me.

Signature of Patient _____ Date _____

Witness _____ Date _____