First Name | Last Name | Perferred | Birthdate | SSN

Address

City | State | Zip

Home Phone | Work Phone | Cell Phone

E mail

Would you like to receive text messages and/or email to confirm appointments? Yes ☐ No ☐

How did you hear about Coastal Dental Group?

_____

Insurance Information- Please provide us your insurance information to the front desk, we will be happy to provide the "courtesy" of filing your insurance for you.

By signing this form you understand that your insurance is a contract between you and your insurance carrier and will be fully responsible for all dental fees not covered by your insurance.

Signature of Responsible Party _____

Coastal Dental Group

Medical History for New Patient

Last Name: First Name: Birthdate:

Name of Medical Doctor:_____ City/State:_____

Emergency Contact_____ Phone_____ Relationship_____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take ANY kind of blood thinners, not listed above?

Do you now or have you EVER taken Fosamax, Boniva, Actonel or any other medication containing biosphonates?

Y N

☐ ☐ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Metals/Acrylic
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

☐ ☐ Other Allergy_____

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	High Blood Pressure
☐	☐	Alzheimer/Dementia	☐	☐	Joint Replacement
☐	☐	Artificial Heart Valve	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Liver Disease
☐	☐	Bleeding Problems	☐	☐	Pregnancy
☐	☐	Cancer	☐	☐	Psychiatric Treatment
☐	☐	Diabetes	☐	☐	Sinus Trouble
☐	☐	Drug Addiction	☐	☐	Stroke
☐	☐	Heart Murmur	☐	☐	Ulcers
☐	☐	Heart Attack	☐	☐	Rheumatic Fever
☐	☐	Hepatitis A, B or C			

Other Medical Problems_____

Please Print Full Name

A

_____

Signature Date:

Coastal Dental Group

Financial Agreement

Last Name: First Name: Birthdate:

Date:

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* Every effort will be made to help me with my insurance, but if they do not pay as estimated, I will still be responsible.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time, unless otherwise agreed upon.
* If sent to collections, I agree to pay all related fees and court costs.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

I have read, understand and fully agree to the above terms and conditions.

☐ Yes
☐ No

_____

Signature

Notice of Privacy Policies

Last Name: First Name: Birthdate:

Date:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

_____

Signature