SAWRIE
FAMILY DENTISTRY

Lucy W. Sawrie, DDS

Tell Us About Yourself

1. GENERAL INFORMATION

PATIENT'S NAME	NICKNAME	DATE OF BIRTH	SEX ☐ Male ☐ Female
ADDRESS		TELEPHONE #	
CITY		STATE	ZIP CODE
EMAIL ADDRESS			
WHO MAY WE THANK FOR REFERRING YOU?			
PARENT'S NAME (IF UNDER 18)	CELL PHONE #	OCCUPATION/EMPLOYER	WORK TELEPHONE #
PARENT'S NAME (IF UNDER 18)	CELL PHONE #	OCCUPATION/EMPLOYER	WORK TELEPHONE #

2. PATIENT MEDICAL INFORMATION

PLEASE ELABORATE IF YOU ANSWER 'YES' TO ANY OF THE FOLLOWING QUESTIONS:

Are you allergic to any medications, food, or other? ☐ Yes ☐ No _____

Are you under medical treatment? ☐ Yes ☐ No _____

Are you taking any medications? ☐ Yes ☐ No _____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No _____

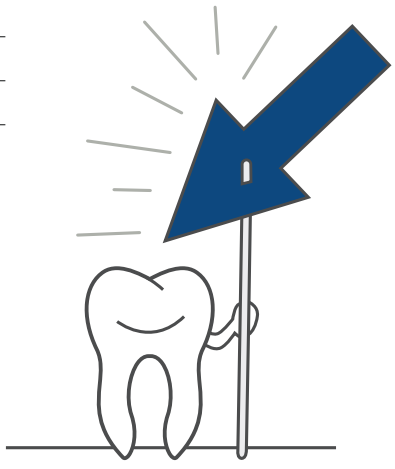
Do you have a history of: *(please check if* 'YES' *and elaborate below)*

☐ Heart Murmur ☐ Asthma ☐ Bleeding disorder ☐ Heart trouble ☐ Sensory disorders ☐ Diabetes
☐ Rheumatic Fever ☐ Seizures ☐ Tuberculosis ☐ Autism ☐ Other

_____

_____

_____



Approval for treatment and form completed by:

_____

SIGNATURE / RELATIONSHIP (IF UNDER 18)

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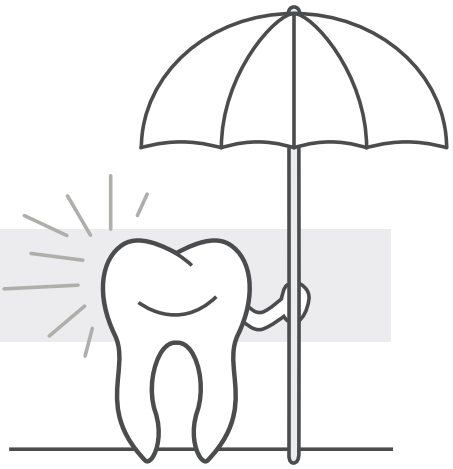

DO YOU HAVE DENTAL INSURANCE?
☐ Yes ☐ No If no, skip to Section 4

3. DENTAL INSURANCE INFORMATION

SUBSCRIBER'S NAME	EMPLOYER'S NAME	DATE OF BIRTH
SOCIAL SECURITY #	INSURANCE CO.	
GROUP #	CARRIER ID #	
ADDRESS		
CITY	STATE	ZIP CODE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ Yes ☐ No If 'NO', skip to Assignment & Release		
SUBSCRIBER'S NAME	EMPLOYER'S NAME	DATE OF BIRTH
SOCIAL SECURITY #	INSURANCE CO.	
GROUP #	CARRIER ID #	
ADDRESS		
CITY	STATE	ZIP CODE
RELATIONSHIP TO PATIENT:		

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE _____ DATE _____

4. NO DENTAL INSURANCE

I understand that I am financially responsible for all charges. I understand that all fees are due on the date of service.

SIGNATURE _____ DATE _____