GREGORY K. BOLLEN, DDS, P.A.
JOSH M. MANSFIELD, DDS

PATIENT'S FULL NAME_____ **SEX:** M F

Name I like to be called_____ **BIRTHDATE**_____ **AGE**_____

RESIDENCE Street_____ City/State_____ Zip_____

Mailing address_____ **HOME PHONE**_____

FATHER'S NAME_____ **SSN**_____ **BIRTHDATE**_____

Address if different from patient: Street_____ City/State_____

EMPLOYER_____ **ADDRESS**_____ **WORK PHONE**_____

Do you have **DENTAL INSURANCE** through FATHER'S employer? YES NO If Yes please complete:

Dental Insurance Co._____ Group #_____

Claim Address_____ Insurance Co. Phone#_____

MOTHER'S NAME_____ **SSN**_____ **BIRTHDATE**_____

Address if different from patient: Street_____ City/State_____

EMPLOYER_____ **ADDRESS**_____ **WORK PHONE**_____

Do you have **DENTAL INSURANCE** through MOTHER'S employer? YES NO If Yes please complete:

Dental Insurance Co._____ Group #_____

Claim Address_____ Insurance Co. Phone#_____

Custodial parent if parents are not living together:_____

Is your child under a physician's care? YES NO For?_____ Physician_____

Has the patient been hospitalized in the past two years? YES NO Explain:_____

List any medications the patient is currently taking:_____

Has the patient ever had any of the following diseases or medical problems?

	YES	NO		YES	NO
Heart Disease or Attack	____	____	Epilepsy or Seizures	____	____
Heart Murmur	____	____	Diabetes	____	____
Rheumatic Fever	____	____	Drug/Alcohol Abuse	____	____
Mitral Valve Prolapse	____	____	Hemophilia	____	____
Heart Surgery/Pacemaker	____	____	Congenital Heart Defect	____	____
Artificial Joints	____	____	Asthma	____	____
High Blood Pressure	____	____	Hepatitis (A or B)	____	____
Cancer/Chemotherapy	____	____	Anemia	____	____
Artificial Heart Valves	____	____	Radiation Treatment	____	____
Tuberculosis	____	____	Sinus Troubles	____	____
A.I.D.S./H.I.V.	____	____	Allergies	____	____

Is the patient allergic to or had an adverse reaction to any of the following medications?

Aspirin Local Anesthetic Nitrous Oxide Codeine Penicillin Erythromycin

Allergic to any other medication?_____

FOR FEMALES:
Are you taking birth control pills? NO YES
Are you pregnant? NO YES Week#_____ Obstetrician_____

Dental History

Have we treated any immediate family members?_____Name_____

How did you hear of our office? Location Phonebook Family Friends Other_____

Who may we thank for referring you to our office?_____

Why have you come to the dentist today?_____

When did you have your last dental exam and x-rays?_____

Name of previous dentist:_____City/State_____

Please make any comments you may have about the condition of your teeth:_____

_____

I authorize the release of any information by Dr. Gregory K. Bollen needed to submit my claims to my insurance company for services rendered or to be rendered. I also authorize my insurance company to pay Dr. Gregory K. Bollen the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

Dr. Gregory K. Bollen values you as a patient. In order to continue to provide exceptional service to all of our patients, timely payment of your account is crucial. The undersigned understands that payment in full for the services which are the subject of this agreement are due at the time those services are rendered unless other arrangements are agreed to in writing prior to the time services are rendered. If you fail to pay your account in full within 60 days following your office visit, we will refer your account to a collection agency. You shall be responsible for paying the fee that the collection agency charges for collection of your debt. The amount of that fee is 40% of your debt. That 40% will be added to your debt and collected by the collection agency. By signing below, you understand and agree to pay that fee. Also, please understand that you are still responsible for any court costs or recovery costs associated with the collection of you debt.

"Should my account become overdue and subsequently transferred to a collection agency, I agree to pay a collection agency fee equal to 40% of my debt owed your office IN ADDITION to the debt I owe. I understand that I am also responsible for any court costs or recovery costs associated with collection of this debt."

_____ _____

Patient Date

_____ _____

Office Representative Date