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

PATIENT'S NAME____________________ **BIRTHDATE**__________ **AGE**______

Name I like to be called________________ **SEX: M F SOCIAL SECURITY #**__________

RESIDENCE Street________________City/State________________Zip________

Mailing address__________________________ **HOME PHONE**__________

EMPLOYER________________ **ADDRESS**______________ **WORK PHONE**__________

Do you have **DENTAL INSURANCE** through your employer? [ ] Yes [ ] No If Yes please complete:

Dental Insurance Co.______________________Group #________________

Claim Address________________________Insurance Co. Phone #__________

SPOUSE NAME____________________ **SSN**____________ **BIRTHDATE**__________

EMPLOYER________________ **ADDRESS**______________ **WORK PHONE**__________

Any **DENTAL INSURANCE** through your spouse's employer? [ ] Yes [ ] No If Yes please complete:

Dental Insurance Co.______________________Group #________________

Claim Address________________________Insurance Co. Phone #__________

Are you under a physician's care? [ ]Yes [ ] No For?________________Physician__________

Have you ever been hospitalized in the past two years?________Explain:________________

List any medications you are currently taking:____________________________

Have you ever taken the medication PHEN/FEN and/or REDUX? YES NO

Have you 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	____	____	A.I.D.S./H.I.V.	____	____
Tuberculosis (TB)	____	____	Sinus Troubles	____	____
Radiation Treatment	____	____	Allergies	__________	

Are you allergic to or have you had an adverse reaction to any of the following medications?

Aspirin Local Anesthetic Nitrous Oxide Codeine Penicillin Erythromycin

Allergic to any other medication?____________________________

FOR WOMEN

Are you pregnant? [ ] Yes [ ] No Week#______Obstetrician________________

Are you taking birth control pills? [ ] Yes [ ] No

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