David J. Novak, DDS, PA

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336-884-1833 • Fax 336-884-4423

PATIENT INFORMATION

PLEASE PRINT LAST NAME FIRST

NAME _____ NICKNAME _____ PHONE _____ CELL _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

AGE _____ BIRTH DATE _____ SEX _____ EMPLOYED BY _____ WORK PHONE _____

EMAIL ADDRESS _____

REFERRED BY _____ MARITAL STATUS _____ SS# _____

IF YOU ARE OVER 18 AND A FULLTIME STUDENT PLEASE LIST THE SCHOOL THAT YOU ARE ATTENDING: _____

NAME OF YOUR PHYSICIAN _____

ARE YOU TAKING MEDICATION? _____ PLEASE LIST _____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____ PLEASE LIST _____

_____

REASON FOR TODAY'S VISIT? _____

_____

HOW LONG HAS IT BEEN SINCE YOUR LAST DENTAL VISIT? _____

_____

WHAT WAS DONE AT THAT TIME? _____

_____

DO YOU HAVE, OR HAVE YOU EVER HAD? PLEASE CIRCLE:

HEART MURMUR	ANEMIA
FAINTING SPELLS	RADIATION THERAPY
HEART CONDITION	DIABETES
MALIGNANCY	EPILEPSY/SEIZURE
ABNORMAL BLOOD PRESSURE	HEPATITIS
TUBERCULOSIS	ASTHMA
ABNORMAL BLEEDING	RHEUMATIC FEVER
POSITIVE HIV TEST	MIGHT YOU BE PREGNANT

I, THE UNDERSIGNED, VERIFY THE ABOVE MEDICAL HISTORY AND INFORMATION TO BE TRUE TO THE BEST OF MY KNOWLEDGE. I ACKNOWLEDGE THAT I WILL BE EXPLAINED THE TREATMENT NECESSARY IF ANY, AND THE COST. I MAY DENY OR WILL CONSENT TO THE RECOMMENDED TREATMENT BY ALLOWING THE PERFORMING OF SUCH SERVICES. I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED AND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES, COPAYMENTS, AND OTHER CHARGES THAT MY INSURANCE DOES NOT COVER.

_____ _____

SIGNATURE DATE

IF MARRIED

SPOUSES'S NAME _____ EMPLOYED BY _____ WORK PHONE _____

IF UNDER 21 OR STUDENT:

FATHER'S NAME _____ MOTHER'S NAME _____ HOME PHONE _____

PARENT'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

FATHER'S EMPLOYER _____ PHONE _____

MOTHER'S EMPLOYER _____ PHONE _____

ARE YOUR PARENTS RESPONSIBLE FOR YOUR ACCOUNT?

DENTAL INSURANCE INFORMATION (IF APPLICABLE)

NAME OF YOUR PRIMARY INSURANCE COMPANY

POLICY HOLDER'S NAME _____ BIRTH DATE _____ SS# _____

SECONDARY INSURANCE

POLICY HOLDER'S NAME _____ BIRTH DATE _____ SS# _____

IN CASE OF EMERGENCY, CONTACT:

I AUTHORIZE RELEASE OF ANY INFORMATION TO THE INSURANCE COMPANY RELATING TO MY CLAIM:

_____

PATIENT OR PARENT DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. DAVID J. NOVAK OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____

INSURED PERSON OR PATIENT DATE

_____

UNINSURED PERSON OR PATIENT DATE

UNINSURED PATIENTS ARE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE