WELCOME

DR. MICHAEL BUTTERWORTH

PATIENT INFORMATION

TODAY'S DATE: ____/____/_____ MALE ____ FEMALE ____

NAME: _____ NICKNAME: _____

BIRTHDATE: ____/____/_____ AGE: _____ SS# _____-_____-_____

MAILING ADDRESS: _____

CELL PHONE: (_____)-_____-_____ WORK: (_____)-_____-_____ EXT:_____

HOME PHONE: (_____)-_____-_____ EMAIL: _____

REFERRED BY: _____ MARITAL STATUS: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY NAME: _____

ADDRESS:_____

PHONE #: (_____)-_____-_____ GROUP #: _____

INSURED'S NAME: _____ INSURED'S SS# _____-_____-_____

RELATION: _____ DOB: ____/____/_____ INSURED'S EMPLOYER _____

SECONDARY DENTAL INSURANCE COMPANY NAME: _____

ADDRESS:_____

PHONE #: (_____)-_____-_____ GROUP #: _____

INSURED'S NAME: _____ INSURED'S SS# _____-_____-_____

RELATION: _____ DOB: ____/____/_____ INSURED'S EMPLOYER _____

ACCOUNT INFORMATION: *person ultimately responsible for the account*

NAME: _____ RELATION: _____ LICENSE #_____

BILLING ADDRESS: _____

EMERGENCY CONTACTS

NAME: _____ RELATION: _____

CELL PHONE: (_____)-_____-_____ WORK: (_____)-_____-_____ EXT:_____

PHYSICIAN: _____ PHONE #: (_____)-_____-_____

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Height:

For Office Use Only

BP: Heart Rate:

Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Chest Pains
☐	☐	Crohns Disease
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV+ AIDS

Y	N	Conditions
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems

Y	N	Conditions
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	COVID-19
☐	☐	
☐	☐	

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Other diseases, conditions or problems the office should be aware of that was not covered:

Signature: _____ **Date:** _____

(If under 18, Parent or Guardian Signature Required)

Michael R. Butterworth, DDS

31059 DuPont Blvd. Dagsboro, DE 19939
302-732-9850

I acknowledge having received a copy of the practice's Notice of Privacy Practices.

PRINTED NAME: _____

SIGNATURE: _____ **DATE:** _____

Michael R Butterworth, DDS
31059 DuPont Blvd./ Dagsboro, DE 19939/ 302-732-9850

Written Financial Policy

Thank you for choosing Dr. Michael Butterworth for your dental needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment options:

*Cash, Check, Visa, Mastercard, American Express or Discover

*NO INTEREST payment plans from Care Credit
***This company offers low monthly payments, no annual fees or pre-pay penalties

Please note:

Dr. Michael R. Butterworth requires payment prior to completion of major treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with most carriers to maximize your benefit and directly bill them for payment. We will collect your portion at the time of service.

A fee of $50 is charged for patients who Cancel appointments same day or No Show for appointments.

Returned checks are subject to $40 fee

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent Signature Date