URGENT DENTAL CARE

Patient Name: _____ Preferred Name: _____
Mailing Address: _____ City: _____ State: _____Zip: _____
DOB: _____ SSN: _____ Daytime Phone: _____
Cell Phone: _____ Work Phone: _____ Gender: Female Male Other
Marital Status: Married Divorced Single Domestic Partner Minor Child
Email address: _____@_____.com

Whom may we thank for referring you to our Practice? _____

Primary Insured

Name: _____ DOB: _____ SSN: _____
Address: _____ City: _____ State: _____Zip: _____
Relation to Patient: Spouse Self Parent/Guardian Partner (circle)
Employer _____ Work Phone _____
Dental Insurance Company _____ ID Number _____

Federal Employees

Federal Employee Medical Insurance: BCBS ID: R _____ GEHA ID # _____

Secondary Insured

Name: _____ DOB: _____ SSN: _____
Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____Zip: _____
Relation to Patient: Spouse Self Parent/Guardian Partner (circle)
Insurance Company: _____ ID Number: _____

Responsible Party

This must be filled out please

Name: _____ Relationship: _____
Mailing Address: _____ City: _____ State: _____Zip: _____
DOB: _____ SSN: _____ Daytime Phone: _____
Employer: _____ Employer Phone: _____

Insurance Policy

Your Insurance Contract is an agreement between you and your insurance company. We are not a party to that contract. Your complete insurance information must be presented at the time services are provided. All insurance co-pays and deductibles must be paid at the time of service. Insurance claims are electronically filed to expedite carrier payments, however, the patient is responsible for any unpaid charges due to exclusions and limitations written in per your plan provisions. I hereby authorize Urgent Care Dental to furnish information to my dental carrier concerning my treatment and I hereby assign to the doctors all payments for dental treatment rendered to myself or my dependents.

Signed: _____ Date: _____

Patient Medical History

Physician: _____ Office Phone: _____ Date of Last Exam: _____

I consider my health to be (circle one); Excellent Good Fair Poor

Do You have or have you had any of the following? Please circle Y for yes or N for no.

Y N Heart Disease
Y N Congenital Heart Lesions
Y N Stent
Y N Prolonged Bleeding Disorder
Y N Hay Fever
Y N Ulcers
Y N Hepatitis Type _____
Y N Kidney Disease
Y N Cancer/Chemotherapy
Y N HIV/AIDS
Y N Fainting Spells
Y N Pregnant
Y N Artificial Joints: Where: _____
Y N Heart Murmur / MVP
Y N Rheumatic Fever
Y N Abnormal Blood Pressure
Y N TB or Lung Disease
Y N Sinus Trouble
Y N Liver Disease
Y N Diabetes
Y N Radiation Therapy
Y N Immune Suppressed Disorder Type _____
Y N STD/Herpes
Y N Glaucoma
Y N Nursing
Y N Stroke
Y N Pacemaker
Y N Anemia
Y N Asthma
Y N Epilepsy/Seizures
Y N Jaundice
Y N Arthritis
Y N Tumor/Malignancy
Y N Hearing Loss
Y N Depression
Y N Taking Birth Control
Y N Implants

Y N Smoke or smokeless tobacco _____ per day How many years? _____ Have you quit Y N When? _____
Y N Substance Abuse What? _____ How often? _____ Have you quit? Y N When? _____
Y N Do you take Fosamax, Boniva, Actonel, Aredia, Zometa, etc. for Osteoporosis or any other condition? Y N
Y N Had major surgery? Year _____ Type _____ Year _____ Type _____

Are you allergic to any of the following (please circle)

Aspirin Ibuprofen Sulfa Drugs Penicillin Codeine Latex Local Anesthetics

Other allergies to medications _____ _____ _____

Please List the medications you are currently taking with dosage and for what condition

Rx: _____ Condition _____ How often? _____
Rx: _____ Condition _____ How often? _____
Rx: _____ Condition _____ How often? _____
Rx: _____ Condition _____ How often? _____

Patient Dental History

What is the reason for your appointment today? _____
Previous Dentist _____ Last visit _____ Last Cleaning _____
Would you like to share the reason for changing dentists? Y N Reason _____
Have you had problems with previous dental treatment? Y N Explain _____
Are you nervous about seeing a dentist? Y N Please Explain _____
How often do you brush? _____ Floss _____

(please circle)

Y N I clench or grind my teeth during the day or while sleeping
Y N My gums bleed while brushing or flossing
Y N I have had orthodontics
Y N I have had oral surgery
Y N My gums feel tender or swollen
Y N I have eating problems
Y N I have had gum surgery
Y N I prefer tooth colored fillings

Y N Would you like to change anything about your smile? What? _____
What are your dental priorities? _____
(e.g.: appearance, dental health, financial considerations, etc.)

Initial Medical/Dental reviewed by:

X_____ Date _____ Assistant/Hygienist _____ Intls.

(Dr. Signature)

Periodic Medical/Dental health reviewed by:

X_____ Date _____ X_____ Date _____
Doctor Patient

X_____ Date _____ X _____Date _____
Doctor Patient