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Welcome!

Part One.....About You

Today's Date: _____/_____/_____

Patient Name: _____

Last First MI

What You Prefer To Be Called: _____ Male___ Female___

Birthdate: ____/____/_____ Age: _____ SS# _____

Mailing Address: _____

_____

City State Zip

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Email Address: _____

How you prefer to be contacted: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____

City State Zip

Occupation: _____

Status: Minor__ Single__ Married__ Divorced__ Separated__ Widowed__

Spouse's Name: _____

Do you have any children? ___Yes ___No How many? _____

Part Two.....Account Info

Person Ultimately Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____

City State Zip

SS #: _____ Drivers License #: _____

Work Phone #: _____ Other Phone #: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Part Three.....Insurance Info

Primary Dental Insurance

Co. Name:

_____

Address: _____

_____

City State Zip

Phone #: (_____) _____

Insured's Sub. ID#: _____

Group Plan: _____

Group #: _____

Insured's Name: _____

Relation: _____ Birthdate: ____/____/_____

Insured's Soc. Sec. #: _____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____

City State Zip

Phone #: (_____) _____

Insured's Sub. ID#: _____

Group Plan: _____

Group #: _____

Insured's Name: _____

Relation: _____ Birthdate: ____/____/_____

Insured's Soc. Sec. #: _____

Part Four.....Emergency Contact

Contact person: _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Medical Doctor: _____

Med. Dr. Phone #: _____

Please Continue on Next Page

Welcome!

Part Five.....Dental Information

Reason for today's visit: _____Exam _____Emergency _____Consultation

Are you in pain? _____No _____Yes How Long/Describe _____

Please indicate by check mark any of the following problems:

___Discomfort, clicking or popping in jaw ___Lost/Broken Filling(s) ___Stained teeth

___Red, swollen or bleeding gums ___Teeth grinding ___Locking jaw

___Sensitive tooth, teeth or gums ___Ringing in Ears ___Bad breath

___Blisters/Sores in or around the mouth ___Broken/Chipped tooth

___Other: _____

Have you ever been told to premedicate with antibiotics before a dental appointment? _____Yes _____ No _____ Don't Know

Previous Dentist: _____

Name Address Phone #

Date of Last Dental Exam: _____ Date of Last Dental X-rays: _____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? _____Soft _____Medium _____Hard

Part Six.....Medical History

What medications are you taking? _____Nerve pills _____Pain Killers (including aspirin) _____Muscle Relaxers _____Stimulants

_____Blood Thinners _____Tranquilizers _____Insulin _____Meds for Osteoporosis

_____Other(s) - please list: _____

Do you have, or have you had, any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cosmetic Surgery
Y N Heart Surgery/Pacemaker	Y N Kidney Problems	Y N Shingles	Y N X-ray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems/Ulcers	Y N Artificial Bones/Joints	Y N Diabetes/Hypoglycemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Frequent Headaches	Y N High/Low Blood Pressure
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	Y N Glaucoma

Please list any other surgeries or medical conditions you have, or ever had: _____

_____

Are you allergic to any of the following? _____Latex _____Penicillin/Amoxicillin _____Tetracycline _____Aspirin ____Sulfa ____Codeine

_____Dental Anesthetics _____Foods:_____ _____Other:_____

Please describe your reaction: _____

Do you use tobacco? ___No ___Yes/How used? _____ How much?_____ How long?_____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ____Yes ____No

Have you ever taken the drug Phen-fen and or Redux? ____Yes ____No

For Women: Are you taking Birth Control pills? _____Yes _____No How many children have you had? _____

Are you pregnant? _____No _____Yes/How far along?_____ Are you nursing? _____Yes _____No

Please Continue on Next Page

Welcome!

Part Seven.....Consent/Treatment Authorization

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made.
- We routinely take diagnostic records every 12 months. We reserve the right to refuse treatment if these x-rays are refused over a 3-year period.
- Appointment times are scheduled only for you. We respect your time, and we ask that you respect ours. Therefore, any 3 failed appointments within a one-year period, or 3 consecutive failed appointments, are considered a reason for dismissal from our practice. *A failed appointment is a cancellation with less than a 24-hour notice, or a failure to show up for a scheduled appointment.*
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

___Adult Patient ___Parent/Guardian

Yearly Updates

I have reviewed this document and certify that it is correct to the best of my knowledge.

Signature: _____ ***Date:*** _____

Signature: _____ ***Date:*** _____

Signature: _____ ***Date:*** _____

Signature: _____ ***Date:*** _____