WHAT'S NEW

1 ABOUT YOU

Today's Date: ____ / ____ / ____ File #: ____

Patient Name: ____
LAST FIRST MI

Mailing Address: ____
(❑ UNCHANGED)

CITY STATE ZIP

Home phone: (____) ____

(____) ____ ____ (____) ____
OFFICE PHONE EXT. CELL PHONE

E-mail Address: ____

Employer: ____
(❑ UNCHANGED)

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Marital Status: ____
(❑ UNCHANGED)

Spouse's Name: ____

2 INSURANCE INFO

Has any of your Insurance Information changed? ❑ No ❑ Yes
If your insurance info has **not** changed, please continue on to block 3.

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____ / ____ / ____

Insured's Employer: ____

____ 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 (if offered at this office).
Initials

Please provide any **new** Primary/Secondary Ins. cards with this form.

3 MEDICAL INFO

What Medications are you taking? (please include over-the-counter drugs) ____

Please list any **new** allergies, diseases, medical conditions, or procedures; include dates when possible: ____

In event of an emergency, whom should we contact? ____

Relation: ____ Phone #: (____) ____ Cell #: (____) ____

Who is your medical doctor? ____ Phone #: (____) ____

Has our office/staff met or surpassed your expectation of treatment? ❑ Yes ❑ No ❑ Somewhat

Comments: (if any) ____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature ____ Date: ____ / ____ / ____

five 5

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation
Are you in pain? ❑ No ❑ Yes How Long? _____
Please indicate ☑ 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: _____
Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know
Previous Dentist: _____ (____) _____
Name Phone#
Last Dental exam: ____/____/____ 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
How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

six 6

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 Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray 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
❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____
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 long? _____ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

- 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 with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- 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 and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)
Initials ____ Date ____/____/____
Comments
Initials ____ Date ____/____/____
Comments
Initials ____ Date ____/____/____
Comments