PATIENT INFORMATION

Today's Date ____________________

Patient Name ____________________

I prefer to be called____________ ____ Male ____ Female

Birthdate ____________ Age ______ SS# ____________

Address ____________________

City/State/ZIP ____________________

Home phone ____________Work phone____________

Cellphone____________E-mail____________

Referred by ____________________

Employer ____________________

Work address ____________________

City/State/ZIP____________________

Occupation ____________________

__Minor __Single __Married __Divorced __Separated __Widowed

Spouse's Name ____________________

Do you have children? _____Yes _____No How many? _________

IN EVENT OF AN EMERGENCY

Whom should be contact? ____________________

Relation ____________________

Billing Address ____________________

Home phone ____________________

Work phone ____________________

Cell phone ____________________

Your Medical Doctor ____________________

Doctor's phone number ____________________

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Company Name ____________________

Address ____________________

City/State/ZIP ____________________

Phone ____________________

Insured's ID # ____________________

Group# (Plan, Local, or Policy#) ____________________

Insured's Name ____________________

Relation ____________________ DOB __________

Insured's Employer ____________________

SECONDARY DENTAL INSURANCE

Company Name ____________________

Address ____________________

City/State/ZIP ____________________

Phone ____________________

Insured's ID # ____________________

Group# (Plan, Local, or Policy#) ____________________

Insured's Name ____________________

Relation ____________________ DOB __________

Insured's Employer ____________________

ACCOUNT INFORMATION

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

Name ____________________

Relation ____________________

Billing Address ____________________

City/State/ZIP ____________________

SS # ____________________

Drivers License # ____________________

Work Phone ____________________

PAYMENT METHOD

____ Cash ____ Check ____ Credit Card

Credit Card # ____________________ Exp. Date _________

________ (initial) *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.*

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 fillings(s)
____ Sensitive tooth, teeth or gums
____ Teeth grinding
____ Red, swollen or bleeding gums
____ Locking jaw
____ Blisters/sores in or around mouth
____ Stained teeth
____ Ringing in ears
____ Broken/chipped tooth
____ Bad breath
____ Other ____

Do you require pre-medication? _____ Yes _____ No _____ Don't know

Previous Dentist's name ____________________________________

Dentist's phone ____

Last dental exam ________________ Last x-rays ________________

Times per day you brush __________ Times per week you floss ________

What type of toothbrush bristles do you use? ____ Soft ____Med ____Hard

How would you rate your smile on scale of 1-10(1=worst,10=best) ______

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 guarantee the information disclosed on this form as correct and accurate 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/Guardian* _____ *Spouse*

MEDICAL HISTORY

What medications are you taking? Please list, including over the counter.

____

____

____

Have you ever taken Bisphosphonates (ex. Aredia/Fosomax) __Yes __ No

Phen-fen/Redux __ Yes __ No

Do you have or have you had any of the following diseases, medical conditions or procedures? (please circle)

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

____ Penicillin/Amoxillin ____ Tetracycline ____Dental Anesthetics

____ Foods: ____________________ ____ Others: ______________

Do you use tobacco? _____ No _____Yes/how used ________________

How much? ____________ How long? ____________

Please rate your general health from 1-10 (1=worst, 10=best) _________

Do you wear contact lenses? _____ No _____ Yes

FOR WOMEN

Are you taking birth control pills? ____ No ____ Yes

Are you pregnant? ____ No ____ Yes (how many months) ________

Are you nursing? ____ No ____ Yes