

WELCOME

1

ABOUT YOU

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

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 #: (____) _____ Ext: _____

Cell Phone #: (____) _____

E-mail Address: _____

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 children? Yes No How many? _____

2

INSURANCE INFO

Primary Dental Insurance

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: _____

Secondary Dental Insurance

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: _____

3

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (____) _____

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

____ 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

4

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (____) _____

Work Phone #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (____) _____

PLEASE CONTINUE ON BACK

5
five

6
six

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)

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: _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) Yes No Phen-fen/Redux Yes No

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

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

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

- ◆ 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.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Initials _____

Signature _____

Date _____ / _____ / _____

Adult Patient Parent or Guardian Spouse

UPDATE
(OFFICE USE)

Initials _____ / _____ / _____
Date

Comments

Initials _____ / _____ / _____
Date

Comments

Initials _____ / _____ / _____
Date

Comments

