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)

____ Initials 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).

4 EMERGENCY CONTACT

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

CONTINUE ON BACK

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	❑ Broken/Chipped tooth
❑ Blisters/Sores in or around the mouth	❑ Teeth grinding	❑ Locking Jaw	❑ Sensitive tooth, teeth or gums
❑ Red, swollen or bleeding gums	❑ Ringing in Ears	❑ Bad breath	❑ Active Decay/Cavity(ies)

❑ Other:_____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Have you ever been treated for Gum Disease? ❑ Y ❑ N

Previous Dentist:_____ (____) _____
Name Address Phone#

Last Dental exam:___/___/___ Last Dental X-rays:___/___/___ Last Dental Cleaning:___/___/___

Have you had problems with previous dental treatment? If so, explain:_____

Times a day you brush?____ Times a week you floss?____ Type of tooth brush bristles? ❑ Soft ❑ Medium ❑ Hard

Rate your Smile from (EXCELLENT=10) 1-10:_____ Would you like whiter teeth? ❑Y ❑N Have you had orthodontic treatment? ❑Y ❑N

Things you would change about your smile?_____

6 MEDICAL HISTORY & INFORMATION

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ **Vitamins/Supplements** _____
❑ 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?

Y N Heart Murmur	Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Disease/Angina	Y N Shingles
Y N Lung Disease	Y N Thyroid Problems	Y N Congenital Heart Defect	Y N Cancer/Tumor(s)/Growth(s)	Y N Hepatitis
Y N Liver Problems	Y N Seizures/Epilepsy	Y N Artificial Heart Valves	Y N Chemotherapy/Radiation	Y N Glaucoma
Y N Blood Disease	Y N Venereal Disease	Y N Mitral Valve Prolapse	Y N X-ray or Cobalt Treatment	Y N Arthritis/Gout
Y N Kidney Problems	Y N Cosmetic Surgery	Y N G.I. Problems/Ulcers	Y N Frequent Thirst/Urination	Y N Leukemia
Y N Scarlet Fever	Y N Dizziness/Fainting	Y N Emphysema/Asthma	Y N Bleeding Problems/Anemia	Y N Chest Pains
Y N Tuberculosis TB	Y N Cold/Fever Blisters	Y N Diabetes/Hypoglycemia	Y N High/Low Blood Pressure	Y N Bruise Easily
Y N HIV+/AIDS/ARC	Y N Blood Transfusion	Y N Psychiatric Problems	Y N Artificial Bones/Joints/Implants	Y N Allergies
Y N Rheumatic Fever	Y N Alcohol/Drug Abuse	Y N Back/Neck Problems	Y N Severe/Frequent Headaches	Y N Nervousness
Y N Sinus Problems	Y N Eating Disorder	Y N Respiratory Problems	Y N Jaw Problems TMJ/TMD	Y N Sleep Apnea

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 ❑ Codeine
❑ 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 Are you taking hormonal replacement? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long?_____ Are you nursing? ❑ Y ❑ N How many children have you had?_____

■ 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.

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

Signature _____ Date___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ___/___/___ Date
Comments

Initials ___/___/___ Date
Comments

Initials ___/___/___ Date
Comments