WELCOME

one 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: ____

Other Phone #s: ____

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? ____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: ____

Insured's SS#: ____

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 SS#: ____

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

Insured's Name: ____

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

Insured's Employer: ____

three 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 for by my insurance company (if offered at this office).
Initials

four IN EVENT OF EMERGENCY

Who should we contact? ____

Relation: ____

Home Phone #: ____

Work Phone #: ____

Who is your Medical Doctor? ____

M.D.'s Phone #: ____

PLEASE CONTINUE ON BACK

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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? 1 2 3 4 5 6 7 8 9 10

six

MEDICAL HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers (including aspirin)
❑ Muscle relaxers ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

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

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

Please list any other medical condition(s) you have or ever had: _____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ 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