

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us.
We will be happy to help.

Patient Information (CONFIDENTIAL)

Name _____ Birth date _____ SS # _____
Minor _____ Single _____ Married _____ Divorced _____ Widowed _____ Separated _____
Home Phone _____ Cell Phone _____ Work Phone _____ Email _____
Address _____
City _____ State _____ Zip _____
Driver's License # _____
Employer _____
If Student, Name of School/College _____ City _____ State _____
Full Time _____ Part Time _____
Spouse (If applicable) _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____ Cell Phone _____
City _____ State _____ Zip _____ Email _____
Driver's License # _____ Birth date _____
Employer _____ Work Phone _____ SS # _____
Is this person currently a patient in our office? Yes _____ No _____

Payment philosophy available upon request.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Address of Insured _____
Birthdate _____ SS # _____ Ins I.D. # _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy ID # _____
Insurance Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES ___ NO ___ IF YES, PLEASE COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient _____
Address of Insured _____
Birthdate _____ SS # _____ Ins I.D. # _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy ID # _____
Insurance Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ Max. annual benefit _____

OVER PLEASE

Patient Medical Information

Physician (M.D.): _____ Office Phone: _____ Date of Last Exam: _____

- Are you under medical treatment now? Yes ___ No ___ If yes, please explain _____
- Have you been hospitalized for any surgical operations or serious illness in the last 5 years? _____
If yes, please explain: _____
- What medications are you taking, including non-prescription medication? _____

- Have you ever taken Fosamax, Boniva, Actonel, or any medications containing bisphosphonates? Yes ___ No ___
- Do you use tobacco? Yes ___ No ___
- Do you use controlled substances? Yes ___ No ___
- Are you wearing contact lenses? Yes ___ No ___
- Are you allergic to or have you had any reactions to the following?

- Local Anesthetic.....Yes ___ No ___
- Penicillin or any other antibiotics.....Yes ___ No ___
- Sulfa Drugs.....Yes ___ No ___
- Barbiturates.....Yes ___ No ___
- Sedatives.....Yes ___ No ___
- Iodine.....Yes ___ No ___
- Aspirin.....Yes ___ No ___
- Any metals (i.e. nickel, mercury, etc.).....Yes ___ No ___
- Latex Rubber.....Yes ___ No ___
- Other (please list) _____

- Do you have a persistent cough or throat clearing not associated with a known illness? Yes ___ No ___

- Do you have or have you had any of the following?

- | | | |
|---|--|---|
| High Blood Pressure..... Yes ___ No ___ | Heart Disease..... Yes ___ No ___ | Chest Pains..... Yes ___ No ___ |
| Heart Attack..... Yes ___ No ___ | Cardiac Pacemaker..... Yes ___ No ___ | Easily Winded..... Yes ___ No ___ |
| Rheumatic Fever..... Yes ___ No ___ | Heart Murmur..... Yes ___ No ___ | Stroke..... Yes ___ No ___ |
| Swollen Ankles..... Yes ___ No ___ | Angina..... Yes ___ No ___ | Hay Fever/Allergies..... Yes ___ No ___ |
| Fainting/Seizures..... Yes ___ No ___ | Frequently Tired..... Yes ___ No ___ | Tuberculosis..... Yes ___ No ___ |
| Asthma..... Yes ___ No ___ | Anemia..... Yes ___ No ___ | Radiation Therapy..... Yes ___ No ___ |
| Low Blood Pressure..... Yes ___ No ___ | Emphysema..... Yes ___ No ___ | Glaucoma..... Yes ___ No ___ |
| Epilepsy/Convulsions... Yes ___ No ___ | Cancer..... Yes ___ No ___ | Recent Weight Loss..... Yes ___ No ___ |
| Leukemia..... Yes ___ No ___ | Arthritis..... Yes ___ No ___ | Liver Disease..... Yes ___ No ___ |
| Diabetes..... Yes ___ No ___ | Joint Replacement/Implant.... Yes ___ No ___ | Heart Trouble..... Yes ___ No ___ |
| Kidney Diseases..... Yes ___ No ___ | Hepatitis / Jaundice..... Yes ___ No ___ | Respiratory Problems... Yes ___ No ___ |
| Aids or HIV Infection... Yes ___ No ___ | Sexually Transmitted Disease. Yes ___ No ___ | Mitral Valve Prolapse... Yes ___ No ___ |
| Thyroid Problem..... Yes ___ No ___ | Stomach Troubles/Ulcers..... Yes ___ No ___ | Other _____ |

11. Women only:

- a) Are you pregnant or think you may be pregnant?..... Yes ___ No ___
- b) Are you nursing?..... Yes ___ No ___
- c) Are you taking oral contraceptives?..... Yes ___ No ___

Dental: Name of previous Dentist and location: _____

- Have you ever experienced any of the following problems with your jaw?
 - Clicking Yes ___ No ___
 - Pain Yes ___ No ___
 - Difficulty in opening or closing Yes ___ No ___
 - Difficulty in Chewing Yes ___ No ___
- Do you have frequent Headaches? Yes ___ No ___
- Do you clench or grind your teeth? Yes ___ No ___
- Have you ever had any prolonged bleeding following extractions? Yes ___ No ___
- Do feel pain in any of your teeth? Yes ___ No ___
- Do you like your smile? Yes ___ No ___

Authorization and Release

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to a third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent/guardian if minor)

Date