

PATIENT INFORMATION

Name _____ Preferred name _____ Date: _____
Parent/Guardian (if Minor child) _____
Address _____ City _____ State _____ Zip _____
Phones (home) _____ (work) _____ (cell) _____
Date of birth _____ (mm/dd/yr) Social Security #: _____
Email Address _____ Occupation _____
Student (Full or Part Time) School Name _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Phones (Home) _____ (Cell) _____
Relationship to Patient: Parent / Guardian / Spouse / Other _____

INSURANCE INFORMATION:

Primary Insured Name: _____ Is insured a patient? Yes/ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Secondary Insured Name: _____ Is insured a patient? Yes/ No

Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

PATIENT MEDICAL HISTORY

Physician's name _____ Phone _____

Are you now under the care of a physician? ? Yes or No If yes please explain:

Have you ever been hospitalized for any surgical procedure or serious illness? Yes or No

Are you taking any medication(s) including non-prescription and supplements? Please list?

Do you or have you had any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> High BP | <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anemia | When? _____ |
| <input type="checkbox"/> Low BP | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Hepatitis Type A / B / C | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> COPD | When? _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Diabetes Type I or II | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Cancer _____ | Did you receive Chemotherapy or Radiation? _____ | |
| <input type="checkbox"/> Other Conditions: | | |

Are you allergic to or have you had any reaction to the following:

- | | |
|--|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Ibuprofen (Advil, Aleve) | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Prescription Pain Medications | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Topical Anesthetics |
| <input type="checkbox"/> Other _____ | |

Do you use tobacco? Yes or No

Do you use alcohol? Yes or No How much and how often: _____

Do you use recreational drugs? Yes or No If yes, list: _____

Do you have a history of Drug Addiction or Alcoholism? _____

WOMEN ONLY:

Are you pregnant? Yes or No Are you nursing? Yes or No

Are you taking Birth control pills? Yes or No Are you post menopausal? Yes or No

DENTAL HISTORY

What is the reason for today's visit? Exam Consult Emergency

Do you have any specific dental concerns? Describe _____

When was your last dental appointment? _____

Typically in the past, did you have routine dental care? Yes or No

How often do you brush your teeth? _____ Do you floss? _____

Are there any sores in your mouth? _____

Do you want to keep your remaining teeth? _____

Are any of your teeth loose? _____

Are you happy with your smile? _____

Do any of your teeth currently hurt? _____

Whom may we thank for referring you? _____

How did you hear about us? Another patient A Friend Yellow Pages Insurance Carrier

Internet Website Facebook Work Other _____

Preferred form of contact for confirming appts:

Phone call (Listed above) Email (Listed Above) Text



Please friend us on Facebook to stay up to date on our current promotions.

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Signature of Dentist _____ Date: _____