

Welcome

All About You!

Pa- Today's Date: ____/____/____
tient
Name: _____
Last First Mi

Preferred Name: _____
 __ male __ female **Birthdate:** ____/____/____

Age: _____ **SS#:** _____

Driver's License #: _____

Mailing Address: _____

City State Zip

Home Phone#: (____) _____

Work Phone #: (____) _____ **Ext:** _____

Cell Phone #: (____) _____

E-Mail Address: _____

Preferred number to call to confirm: __home __work __cell
Status: __Minor__Single__Married__Divorced__other

Spouse's Name: _____

Do you have children? __Yes __No **How Many?** _____

Referred By: _____

Employer: _____ **How long?** _____

Account Information

Person ultimately responsible for the account

Name: _____

Relation: _____

Billing Address: _____

City State Zip

SS#: _____

Driver's License #: _____

Work Phone #: (____) _____ **Ext:** _____

**Payments and co-payments are due at the time
 services are rendered**

Insurance

Primary Dental Insurance

Ins. Name: _____

Address: _____

City State zip

Phone #: (____) _____

Insured's ID#: _____

Group # (plan, local, or policy #): _____

Insured's name: _____

Relation: _____ **Birthdate:** ____/____/____

Employer: _____

Secondary Dental Insurance

Ins. Name: _____

Address: _____

City State zip

Phone #: (____) _____

Insured's ID#: _____

Group # (plan, local, or policy #): _____

Insured's name: _____

Relation: _____ **Birthdate:** ____/____/____

Employer: _____

For Emergency

**Whom should we contact in the event of
 an emergency?**

Name: _____

Relation: _____

Home Phone#: (____) _____

Work Phone #: (____) _____ **Ext:** _____

Cell Phone #: (____) _____

Medical Doctor? _____

Doctor's Phone#: (____) _____

Please continue on reverse side

Dental Information

Reason for your visit today? _____

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 mouth broken/chipped tooth

other: _____

Previous dentist: _____ (____) _____

Name

phone #

Last dental exam: ___/___/___ last x-rays: ___/___/___ times a day you brush//floss? ___/___

What type of tooth brush bristles do you use? soft medium hard

Rate your smile 1-10? _____ (with 10 being the best)

Medical History

What medications are you taking? nerve pills pain killers (including aspirin) muscle relaxers stimulants

blood thinners tranquilizers insulin meds for osteoporosis others (please list): _____

Have you ever taken : bisphosphonates (ex. Aredia/fosamax) yes no Phen-fen/Redux yes no

Do you require pre-medication? yes no don't know

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

heart attack/ stroke

thyroid problems

cancer/tumors

cosmetic surgery

heart surgery/pacemaker

kidney problems

shingles

x-ray or cobalt treatment

heart murmur

liver problems

hepatitis

chemotherapy

rheumatic fever

respiratory problems

HIV+/ AIDS/ARC

asthma

mitral valve prolapsed

sinus problems

arthritis/ rheumatism

difficulty breathing

Artificial valves

stomach problems/ulcers

artificial bones/joints

diabetes/hypoglycemia

heart disease

psychiatric problems

emphysema

leukemia

congenital heart defect

venereal disease

fainting/seizures/epilepsy

anemia

cheat pains

alcohol/drug abuse

severe/frequent headaches

high/low blood pressure

scarlet fever

tuberculosis TB

frequent neck pain

bleeding problems

nervousness

jaw problems TMJ/TMD

back problems

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

Any other allergies? _____

Do you use tobacco? yes no /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? _____ How many children have you had? _____ Are you pregnant? _____ Are you nursing? _____

- 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 your visit. If account is not paid within 90 days of the date of service and no arrangements have been made with the business manager, you will be responsible for interest charges, late fees, legal fees, collections agency fees, 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: ___/___/___