

## 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

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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 # below (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. IN EVENT OF EMERGENCY

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Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Who is your Medical Doctor: \_\_\_\_\_

Medical Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_

### 5. DENTAL INFORMATION

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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? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

## 6. MEDICAL HISTORY

What medications are you taking?

- Nerve pills                       Pain killers (including aspirin)                       Muscle relaxers  
 Stimulants                                       Blood Thinners                                       Tranquilizers  
 Insulin     Meds for Osteoporosis                                       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?

- |                                    |                                    |                                       |                                     |
|------------------------------------|------------------------------------|---------------------------------------|-------------------------------------|
| <b>Y N</b> Heart Attack/Stroke     | <b>Y N</b> Thyroid Problems        | <b>Y N</b> Cancer/Tumors              | <b>Y N</b> Cosmetic Surgery         |
| <b>Y N</b> Heart Surg./Pacemaker   | <b>Y N</b> Kidney Problems         | <b>Y N</b> Shingles                   | <b>Y N</b> Xray or Cobalt Treatment |
| <b>Y N</b> Heart Murmur            | <b>Y N</b> Liver Problems          | <b>Y N</b> Hepatitis                  | <b>Y N</b> Chemotherapy             |
| <b>Y N</b> Rheumatic Fever         | <b>Y N</b> Respiratory Problems    | <b>Y N</b> HIV+/AIDS/ARC              | <b>Y N</b> Asthma                   |
| <b>Y N</b> Mitral Valve Prolapse   | <b>Y N</b> Sinus Problems          | <b>Y N</b> Arthritis/ Rheumatism      | <b>Y N</b> Difficulty Breathing     |
| <b>Y N</b> Artificial Valves       | <b>Y N</b> Stomach Problems/Ulcers | <b>Y N</b> Artificial Bones/Joints    | <b>Y N</b> Diabetes/Hypoglycemia    |
| <b>Y N</b> Heart Disease           | <b>Y N</b> Psychiatric Problems    | <b>Y N</b> Emphysema                  | <b>Y N</b> Leukemia                 |
| <b>Y N</b> Congenital Heart Defect | <b>Y N</b> Venereal Disease        | <b>Y N</b> Fainting/Seizures/Epilepsy | <b>Y N</b> Anemia                   |
| <b>Y N</b> Chest Pains             | <b>Y N</b> Alcohol/Drug Abuse      | <b>Y N</b> Severe/Frequent Headaches  | <b>Y N</b> High/Low Blood Pressure  |
| <b>Y N</b> Scarlet Fever           | <b>Y N</b> Tuberculosis TB         | <b>Y N</b> Frequent Neck Pain         | <b>Y N</b> Bleeding Problems        |
| <b>Y N</b> Nervousness             | <b>Y N</b> Jaw Problems TMJ/TMD    | <b>Y N</b> Back Problems              | <b>Y N</b> 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: \_\_\_\_\_  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    How many children have you had? \_\_\_\_\_

Are you pregnant?  No  Yes/How long? \_\_\_\_\_ Are you nursing?  Yes  No

- 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.

\_\_\_\_\_ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

INITIALS

Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- Adult Patient     Parent or Guardian     Spouse

### OFFICE USE ONLY

Dentist's Signature: \_\_\_\_\_