

Welcome! Thank you for selecting our dental health care team. We strive to provide the best possible dental care. If you need assistance completing this form, please ask. We'll be happy to help you.

ABOUT YOU

Today's Date: ____/____/____

Patient Name: _____
Last First MI

What you prefer to be called: _____

Birthdate: ____/____/____ SSN# _____

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 How Many? _____ No

INSURANCE INFORMATION

Primary Dental Insurance
Company Name: _____
Address: _____

City State Zip

Phone #: _____

Group, Plan or Policy #: _____

Insured's SSN #: _____

Relationship to Patient: _____

Insured's Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance
Company Name: _____
Address: _____

City State Zip

Phone #: _____

Insured's SSN #: _____

Group, Plan or Policy #: _____

Insured's Name: _____

Relation to Patient: _____

Insured's Date of Birth: ____/____/____

Insured's Employer: _____

ACCOUNT INFORMATION

Person ultimately responsible for account
Name: _____

Relation to Patient: _____

Billing Address: _____

City State Zip

Driver's License #: _____

Work Phone #: _____

Payment Method: Cash Check Credit Card

Credit Card # _____ Expiration _____

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. _____ Initials

IN EVENT OF EMERGENCY

Who should we contact?
Name: _____

Relation to Patient: _____

Home Phone #: _____

Work Phone #: _____

Other Phone #'s: _____

Your Medical Dr: _____

M.D.'s Phone #: _____

PLEASE CONTINUE ON BACK →

DENTAL INFORMATION

Reason for today's visit: Exam Emergency Consultation Second Opinion Smile Analysis Whitening Other
Are you in pain? No Yes If yes, please indicate location: Upper Right Upper Left Lower Right Lower Left
Please indicate with a check any of the following problems:

<input type="checkbox"/> Discomfort, clicking or popping in jaw:	<input type="checkbox"/> Lost/Broken Fillings	<input type="checkbox"/> Stained Teeth
<input type="checkbox"/> Red, swollen or bleeding gums	<input type="checkbox"/> Teeth grinding	<input type="checkbox"/> Locking Jaw
<input type="checkbox"/> Sensitive tooth, teeth, gums	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Bad breath
<input type="checkbox"/> Blisters/sores in or around the mouth	<input type="checkbox"/> Broken/chipped tooth or bridgework	
<input type="checkbox"/> Ill-fitting partial or full denture	<input type="checkbox"/> Other _____	

Do you require pre-medication? Yes If yes, what medication? _____ No Don't know

Previous Dentist: _____

Name _____ Area Code _____ Phone # _____
Last dental exam: ____/____/____ Last dental x-rays: ____/____/____

How many times a day do you brush your teeth? _____ How many times a week do you floss your teeth? _____

What type of toothbrush bristles do you use? Soft Medium Hard Electric toothbrush

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

Please inform our staff of the medications you are currently taking.

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

<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> Cosmetic Surgery
<input type="checkbox"/> Heart Surgery/Pacemaker	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles	<input type="checkbox"/> X-ray or Cobalt Treatment
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> HIV+/AIDS/ARC	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Artificial Valves	<input type="checkbox"/> Stomach Problems/Ulcers	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Diabetes/Hypoglycemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Jaw Problems TMJ?TMD	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Glaucoma

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

Are you allergic to or have you had a reaction to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin
Dental Anesthesia Other(s): _____

Do you use tobacco? No Yes/How used? _____ How often? _____ For how long? _____ yrs.

Please rate your general health from 1-10 (Best): _____ Do you wear contact lenses? Yes No

For Women: Are you taking oral contraceptives? Yes No Are you/could you be pregnant? No Yes/How long ____ wks.
Are you nursing? Yes No

All Patients: PLEASE REMEMBER TO INFORM OUR OFFICE OF ANY FUTURE CHANGE IN YOUR MEDICAL HISTORY

By signing this form I understand and agree to the following office policies of JAMES C. DEE, D.M.D., MAGD
We require payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If account is not paid within 90 days of the date of service, the patient is responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.

I hereby give my consent to James C. Dee, D.M.D., MAGD, to use my dental photographs, slides, videos, or any other image, with or without my name, for educational purposes and in the use of promoting esthetic dentistry. I have completed this form truthfully, and understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such dental care, to third party payers/ health practioners. I understand that my dental insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

