

DENTAL CENTERS OF MISSOURI

16641 East 23rd Street, independence, Missouri 64055

Telephone: (816) 833-2700 * Fax:(816) 836-3480

www.dentalcentersofmissouri.com

When was your last dental exam? _____

Today's Date: _____

Reason for appointment: _____

How did you hear about us? _____

Patient Information

Patients Name: _____ D.O.B. ____/____/____ Age ____ M ____ F ____
(Last) (First)

Address: _____
(Street Address) (City) (State) (Zip Code)

Home #: _____ Cell phone #: _____ Business #: _____

*Drivers license #: _____ Social Security #: _____ Marital Status: _____

Parent/ Guardian Information (If patient is under age please fill out portion below)

Name: _____ D.O.B. ____/____/____ M ____ F ____
(Last) (First)

Address: _____
(Street Address) If Different from above (City) (State) (Zip Code)

Home #: _____ Cell phone #: _____ Business #: _____

Social Security #: _____ Relation to patient: _____

Occupation Information

Name Of Employer: _____ Occupation: _____

Employers Ph#: _____ No. Years Employed: _____

Employers Address: _____
(Street Address) (City) (State) (Zip Code)

Insurance Information

*Primary Insurance Carrier

Employee's Name: _____ Name of Company: _____

SSN: _____ Name of Insurance: _____ Group#: _____

*Secondary Insurance Carrier

Employee's Name: _____ Name of Company: _____

SSN: _____ Name of Insurance: _____ Group#: _____

*Any Additional Insurance

Employee's Name: _____ Name of Company: _____

SSN: _____ Name of Insurance: _____ Group #: _____

Signature: _____

Date: _____

Medical Information

Check the areas that apply to you:

Allergies: (check only that apply) _____ Check if NONE Apply

Seasonal Amoxicillin Keflex Penicillin
 Sulfa Iodine Aspirin Epinephrine
 Local Anesthetic Codeine Other: Please Specify: _____

Medical Alerts: (check only that apply) _____ Check if NONE Apply

Rheumatic Fever Thyroid Problems Tuberculosis
 Heart Murmur Lung Problems Herpes
 Mitral Valve Prolapse Ulcer or Stomach Problems Venereal
 Pacemaker Hepatitis AIDS
 Open Heart Surgery Jaundice A.R.C.
 Heart Valve Replacement Epilepsy HIV
 Bleeding Disorder Nervous Disorder High Blood Pressure
 Clotting Disorder Arthritis Low Blood Pressure
 Asthma Diabetes Hip Replacement
 Liver Problems Joint Replacement Any Other Illness Specify:

Do you currently smoke? No Yes If yes, how many a day/week: _____

If yes, are you interested in quitting? No Yes Someday Not sure Have tried in Past

Are you currently under the care of a physician? _____ No Yes

If yes, reason: _____

When was your last physical exam? _____

Are you presently taking any medications? _____ No Yes

If Yes, Please List: _____

Have you ever been hospitalized? If yes, Date: ____/____/____ _____ No Yes

Reason: _____

Have you had X-ray treatments or Chemotherapy: _____ No Yes

Do any wounds heal slowly or present complications? _____ No Yes

Name and Phone Number of your Physician: _____

Pharmacy Name and Number: _____

Women:

Are you presently taking birth control: _____ No Yes

Are you pregnant or is there a chance you might be? _____ No Yes

**Please note if you are unable to attend your appointment we request that you notify our office 48 hours in advance to cancel. If cancellation is on the day of your scheduled appointment there will be a fee of \$25.00 to \$50.00 per scheduled treatment hour charged to you. Please sign below stating that you understand and are aware of this agreement.

Signature _____

Date _____