

# Welcome!!!

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us become better acquainted, please fill out this form completely in ink and sign all the pages. If you have any questions or concerns, please let us know.*

**PATIENT INFORMATION (CONFIDENTIAL)**

Full Name: \_\_\_\_\_ What would you like us to call you?: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State & Zip: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile/Pager #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Would you like a reminder call for your appointments?  YES  NO

How would you like us to verify your appointments?  HOME PHONE  WORK PHONE  MOBILE/PAGER  E-MAIL

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer Name (Patient/Parent's): \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Main Reason For Visit Today? \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Date Of Last Dental Visit: \_\_\_\_\_

**PARENT (for minors) /SPOUSE INFORMATION (Please fill out completely.)**

MOTHER/WIFE		FATHER/HUSBAND	
Name:		Name:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Work Phone:		Work Phone:	
DL#	DOB:	DL#	DOB:
SS#		SS#	

Person Financially Responsible: \_\_\_\_\_

**\*\*Please list any of your family members who are patients in our office? \_\_\_\_\_**

**PATIENT DENTAL HISTORY**

	YES	NO
Do you floss regularly?		
Have you ever had instruction on the correct method of brushing your teeth?		
Have you had any instructions on the care of your gums?		
Are your teeth sensitive to hot or cold liquids/foods?		
Are your teeth sensitive to sweet or sour liquids/foods?		
Do you feel pain in any of your teeth?		
Do you have any sores or lumps in or near your mouth?		
Have you had any difficult extractions in the past?		
Have you had any prolonged bleeding following an extraction?		
Have you had any orthodontic work?		
Is there anything about the appearance of your teeth that you would change? (What?)		
Have you had any bad experiences in a dental office? If yes, please briefly explain		

*I authorize Parmer Lane Family Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.*

\_\_\_\_\_  
**Signature of patient (or parent if patient is a minor)**

## HEALTH INFORMATION

Medical Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Are you under medical care now? (If so, please describe) \_\_\_\_\_

Please list any medications you are taking (including non prescription) \_\_\_\_\_

Do you use tobacco products? (Re: cigarettes, smokeless tobacco) \_\_\_\_\_

Do you have or have you had any of the following health problems? All information is confidential and helps us determine what medicines and treatments are best for you. **(Be sure to fill chart out completely.)**

**H If you have any of the starred conditions, please call the office prior to your appointment... Pre medication may be required.**

Yes	No		Yes	No	
		Diabetes			Organ Transplant <b>H</b>
		Kidney Dialysis <b>H</b>			Joint Replacement <b>H</b> or Implant <b>H</b>
		Rheumatic Fever <b>H</b>			Radiation Treatment
		Heart Murmur <b>H</b>			Stroke
		Valve Disorders <b>H</b>			Anemia
		Heart Trouble, Heart Attack			Frequently Tired or Easily Winded
		Heart Disease			Liver Disease
		Cardiac Pacemaker			Ulcers, Stomach or Mouth
		High or Low Blood Pressure (Please specify)			Respiratory Problems, Tuberculosis
		Asthma			Eye or Ear Problems
		Hepatitis (Specify A, B or C) Year:			Epilepsy or Seizures
		Frequent Illness, Lowered Immunity			Venereal Disease, any type
		Bleeding Disorder, Hemophilia			Unusual Weight Loss or Gain
		Blood Transfusions Reason:			HIV + or AIDS
		Cancer, Tumors, Cysts			Other

**Allergies (Please answer yes or no- do not leave blank):**

Are You Allergic To Penicillin? \_\_\_\_\_ Local Anesthetics? \_\_\_\_\_ Aspirin? \_\_\_\_\_ Iodine? \_\_\_\_\_ Codeine? \_\_\_\_\_  
 Sulfa Drugs? \_\_\_\_\_ Latex Rubber? \_\_\_\_\_ Please list any other allergies: \_\_\_\_\_

Is there any other health information we should know? \_\_\_\_\_

Are You Pregnant? \_\_\_\_\_ Due Date: \_\_\_\_\_ Nursing? \_\_\_\_\_ Oral Contraceptives? \_\_\_\_\_ **(Please inform us if you become pregnant.)**

**Please inform us if your health information should change.**

Whom should we contact in case of an emergency? **(Please do not leave this blank)**

Name: \_\_\_\_\_ Phone? \_\_\_\_\_ Relationship? \_\_\_\_\_

Closest relative or friend not living with you? \_\_\_\_\_ Phone: \_\_\_\_\_

*To my knowledge the above information is correct and complete. I understand that providing incorrect information can be dangerous to my health. If the patient is a minor, permission is hereby given for dental treatment as deemed necessary to be performed in our office or until written notice is given discontinuing this permission. I agree to be financially responsible for all expenses incurred for myself or my dependents.*

Date: \_\_\_\_\_

Signature of patient (or parent if patient is a minor)

**★OFFICE USE ONLY★**

Reviewed By Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL UPDATES (to be filled out at future appointments)**

DATE	PATIENT'S/ GUARDIAN'S SIGNATURE	CHANGES IN MEDICAL HISTORY	Doctor's Initials

## **FINANCIAL INFORMATION**

*(Please be sure to fill out completely.)*

### **Dental Insurance**

*We will be happy to file your primary insurance for you, provided they will pay us directly. You will be responsible for filing any secondary insurance. All copays and/or deductibles are due when services are rendered.*

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date Employed: \_\_\_\_\_ Employee ID# (if applicable): \_\_\_\_\_

Employer's Name & Address: \_\_\_\_\_

Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address (Claims Address): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number to Verify Benefits (800 #): \_\_\_\_\_

*I authorize Parmer Lane Family Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.*

\_\_\_\_\_  
*Signature of patient (or parent if patient is a minor)*

### **Assignment of Benefits**

*I hereby authorize payment of dental benefits otherwise payable to me directly to Parmer Lane Family Dentistry.*

\_\_\_\_\_  
*Signature of patient (or parent if patient is a minor)*

### **Referrals**

Occasionally, it may be necessary to refer patients to another medical / dental professional. If using your medical insurance for any treatment, you may need a referral authorization from your medical carrier in order to receive benefits. If a referral is necessary, Dr. Devine or Dr. Byler may need to speak with another healthcare practitioner. This may include protected health information and treatment records.

*I understand that I am responsible for attaining any referral authorizations necessary for my medical insurance. I authorize Parmer Lane Family Dentistry to release any information including health information, diagnosis and the records of any treatment or examination rendered to me or my dependents to health practitioners.*

\_\_\_\_\_  
*Signature of patient (or parent if patient is a minor)*

(Over Please)

# DON'T WAIT TILL IT HURTS

Name: \_\_\_\_\_

Periodontal Disease is painless. It affects 87% of the population, most of which are unaware of the problem. There are warning signs and we want you to be aware of them.

1. Do your gums bleed when you brush, floss or use a toothpick?

YES \_\_\_\_\_ NO \_\_\_\_\_

2. Are your gums red, swollen or tender?

YES \_\_\_\_\_ NO \_\_\_\_\_

3. Are your gums pulling away from your teeth?

YES \_\_\_\_\_ NO \_\_\_\_\_

4. Do you see pus between your teeth and gums when the gums are pressed?

YES \_\_\_\_\_ NO \_\_\_\_\_

5. Are your permanent teeth loose or separating?

YES \_\_\_\_\_ NO \_\_\_\_\_

6. Has there been any change in the way your teeth fit together when you bite?

YES \_\_\_\_\_ NO \_\_\_\_\_

7. Do you have chronic bad breath?

YES \_\_\_\_\_ NO \_\_\_\_\_

IF THE ANSWERS TO ANY OF THESE QUESTIONS IS "YES", YOU OWE IT TO YOURSELF TO TELL YOUR DENTIST OR HYGIENIST. DON'T WAIT UNTIL IT IS TOO LATE.