Design Dentistry, LLC

☐ New Patient

Date_____ ☐ Update

PATIENT INFORMATION

Name_____ Birthdate_____ ☐ Male ☐ Female
First MI Last

Address_____ City_____ State_____ Zip_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

Soc. Sec.#_____

Employer_____ Occupation_____ Work #_____

If Minor, lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other

If patient is a student, Name of School/College_____ City_____ State_____

Whom may we thank for referring you?_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____ Relation to Patient_____

Address and home phone # **if different from above**_____

Employer_____ Occupation_____ Work #_____

Soc. Sec. #_____ Birthdate_____

Currently a patient in our office? ☐ Yes ☐ No

PHONE NUMBERS

Home #_____ Work #_____ Ext.____ Cell Phone #_____

Best time and place to reach you_____

In case of emergency who should be notified?_____

Relationship_____ Phone #_____

SUBSCRIBER/ENROLLE DENTAL INSURANCE INFORMATION

Please supply card

Name of Insured_____ Relation to Patient_____

Birth Date_____ Social Security #_____

Employer_____ Subsriber/Enrolle ID #_____

Insurance Co._____ Group #_____

Is patient covered by additional dental insurance? ☐ Yes ☐ No **If yes, please supply card.**

DENTAL HISTORY

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of Last Dental Visit_____

Last Pan/FMX_____ Last Bitewings_____

Please check if you have any of the following:

☐Bad Breath ☐Bleeding Gums ☐Grinding Teeth

☐Periodontal treatment ☐Clicking or Popping Jaw

☐Loose Teeth/Broken Fillings ☐Sensitivity to Heat

☐Sensitivity to Sweets ☐Sensitivity to Cold

☐Sores or growths in your mouth

☐Food Collection between Teeth

PLEASE COMPLETE BOTH SIDES

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit_____

Have you had any serious illnesses or operations? ☐Yes ☐ No If yes, describe_____

_____

Have you ever had a blood transfusion? ☐Yes ☐ No If yes, approximate date_____

Women: Are you pregnant? ☐Yes ☐ No Nursing? ☐Yes ☐ No

Taking birth control pills? ☐Yes ☐ No

Check if you have had any of the following:

☐ Aids	☐ Cortisone Treatments	☐ Hepatitis Type_____	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting/Dizziness	☐ Liver Disease	☐ Swelling of Feet/Ankles
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	Describe_____	☐ RadiationTreatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Codeine ☐ Penicillin

☐ Latex ☐ Sulfa

☐ Other_____

_____

Are you happy with the appearance of your smile? ☐ Yes ☐ No

What would you change if you could?_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ Date_____

Signature of patient or parent if minor

Payment is due in full at time of treatment unless arrangements have been approved.