VALLEY VIEW DENTAL CARE

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About You

Todays Date: _____/_____/_____
Patient Name:_____
Last First MI
What You Prefer To Be Called:_____
Circle one: Male Female
Birthdate:_____/_____/_____ **Age:**_____
Social Security Number: _____ - _____ - _____
Mailing Address: _____
_____
City State ZIP
Home Phone #: _____
Work Phone #:_____
Cell Phone #:_____
Referred by: _____
Employer:_____**How long:**_____
Employer's Address:_____
_____
City State ZIP
Occupation:_____
Circle one: Minor Single Married
Divorced Separated Widowed
Spouse's Name:_____
Do you have children (circle): Yes No
How Many Children: _____

Insurance Info

Primary Dental Insurance
Co. Name_____
Address:_____
_____
City State ZIP
Phone #:(_____)_____
Insured's ID#:_____
Group ID# (Plan, Local, or Policy #)_____
Insured's Name:_____
Relation:_____
Date of Birth: _____/_____/_____
Insured's Employer: _____
Seconday Dental Insurance
Co. Name_____
Address:_____
_____
City State ZIP
Phone #:(_____)_____
Insured's ID#:_____
Group ID# (Plan, Local, or Policy #)_____
Insured's Name:_____
Relation:_____
Date of Birth: _____/_____/_____
Insured's Employer: _____

In Event of Emergency

Whom should we contact?_____ **Relation:**_____
Home Phone #:(_____)_____ **Work Phone #:(_____)**_____
Cell Phone #: (_____)_____ **Medical Doctor's Phone:** _____
Who is your Medical Doctor: _____ **Hospital:**_____

Account Information

Person Ultimately Responsible for Account
Name: _____ **Relation to Child:** _____
Billing Address:_____
City State ZIP
_____ _____/_____/_____ _____
Social Secuirty Date of Birth Drivers License #
( )_____ _____ (_____)_____
Work Number # EXT. Cell Phone #
Payment Method: (circle) CASH CHECK Credit Card
#_____ _____/_____
Credit Card Number EXP.
_____ **I heareby authorize assignment of my rights and benefts directly to the I am solely responsible**
Initial **for any balance not paid by my insurance company (if offered at this office).**

Dental Information

Reason for visit: (circle) Exam Emergancy Consultation Other:_____
Are you in pain? (circle) Yes No How long? _____
Please Indicate [X] Any of the Following Problems:
[ ] Discomfort, clicking or popping jaw [ ] Lost/Broken Filling(s) [ ] Stained Teeth
[ ] Sensitive tooth, teeth or gums [ ] Ring in Ears [ ] Bad Breath
[ ] Red, swollen or bleeding gums [ ] Teeth Grinding [ ] Locking Jaw
[ ] Blisters/Store in or around the mouth [ ] Broken Chipped Tooth [ ] Other: _____
Do you require pre-medication? (circle) YES NO I DON'T KNOW
Previous Dentist: _____ **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? (circle) Soft Medium Hard
How would you rate your smile? (worst) **1 2 3 4 5 6 7 8 9 10** (best)

Medical History

Please indicate [X] any of the following medications and questions:
[ ] Nerve Pills [ ] Pain Killers (including aspirin) [ ]Muscle relaxers [ ]Stimulants [ ] Blood Thinners
[ ] Tranquilizers [ ] Insulin [ ] Osteoporosis [ ] Other(s): _____
Have you ever taken: Bisphoshonates (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?
[ ] Heart Attack/Stroke [ ] Thyroid Problems [ ] Cancer/Tumors [ ] Cosmetic Surg. [ ] Heart. Surg/Pacemaker
[ ] Heart Murmur [ ]Liver Problems [ ]Hepatitis [ ]Kidney Problems [ ]Shingles
[ ]Chemotherapy [ ] Rheumatic Fever [ ]Respiratory Problems [ ]Sinus Problems [ ]Asthma
[ ]Mitral Valve Prolapse [ ]Hiv+/AIDS/ARC [ ]Stomach Problems/Ulcers [ ]Difficulty Breathing
[ ]Xray or Cobalt Treatment [ ]Arthritis/Rheumatism [ ] Artificial Bones/Joints [ ]Diabetes/Hypoglycemia
[ ]Psychiatric Problems [ ]Emphysema [ ]Fainting/Seizures/Epilepsy [ ]Leukemia
[ ]Congenital Heart Defect [ ] Venereal Disease [ ]Severe/Frequent Headaches [ ]Anemia
[ ]Alcohol/Drug Abuse [ ]Chest Pains [ ]Frequent Neck Pains [ ]Bleeding Problems
[ ]High/Low Blood Pressure [ ]Scarlet Fever [ ]Tuberculosis TB [ ]Back Problems
[ ]JawProblems TMJ/TMD [ ]Nervousness [ ]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 [ ]Aspirine
[ ]Dental Anesthetics [ ]Foods [ ]Other:_____
Do you use tabacco? [ ]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 Contraceptives? [ ]Yes [ ]No How many children do you have? _____
Are you pregnant? [ ]Yes [ ]No If 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 requres 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 above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibilityto inform this office of any changes to the information i have provided.

Signature: _____ **Date:** _____**/**_____**/**_____