

Welcome

Welcome

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WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Date _____

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? Yes No

Dentist _____ Medical Doctor _____ Referred By _____

Driver's Lic.# _____ Nearest relative not living with you _____ Tel. (_____) _____

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: Cash Check Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

Who will be responsible for your account?

(If self, skip to next section) Self Spouse Father Mother Other _____

Name _____ S.S.# _____ Birth Date _____ Age _____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information (if different from above)

Name _____ Relation _____ S.S.# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

Student: Full Time Part Time Not School Name/Address _____

Married Divorced Legally Separated Widow Single _____

Employed: Full Time Part Time Retired Not Do you belong to a PPO or HMO? Yes No

PRIMARY INSURANCE COMPANY

Insurance Type: Dental Medical

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: M F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

SECONDARY INSURANCE COMPANY

Insurance Type: Dental Medical

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: M F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

DENTAL INFORMATION

Reason for today's visit: Exam Consultation Emergency Are you in pain? Yes No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Discomfort, clicking, or popping in jaw | <input type="checkbox"/> Lost / broken filling(s) | <input type="checkbox"/> Stained teeth | <input type="checkbox"/> Difficulty closing jaw |
| <input type="checkbox"/> Red, swollen, or bleeding gums | <input type="checkbox"/> Teeth grinding / clenching | <input type="checkbox"/> Locking jaw | <input type="checkbox"/> Difficulty opening jaw |
| <input type="checkbox"/> A removable dental appliance | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose / shifting teeth |
| <input type="checkbox"/> Blisters / sores in or around the mouth | <input type="checkbox"/> Broken / chipped tooth | <input type="checkbox"/> Burning tongue / lips | <input type="checkbox"/> Food caught between teeth |
| <input type="checkbox"/> Prolonged bleeding from an injury / extraction | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Grind / clench teeth | <input type="checkbox"/> Swelling / lumps in mouth |
| <input type="checkbox"/> Recent infections or sore throat | <input type="checkbox"/> Toothache | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> My teeth are sensitive to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/> Biting | | | |

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

What type of tooth bristles do you use? Soft Medium Hard How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

MEDICAL HISTORY

Are you in good health? Yes No Height _____ Weight _____ Are you under the care of a physician? Yes No

Have you had any illness, operation, or been hospitalized in the past five years? Yes No

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

Y	N	Y	N	Y	N	Y	N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever		Asthma		Bleeding tendency		Low blood sugar	
Mitral valve prolapse		Hay fever / Sinus problems		Jaundice / Liver disease		Kidney trouble	
Heart murmur		Snoring / Sleep apnea		Hepatitis		Are you on dialysis	
High blood pressure		Respiratory problems		Infectious mononucleosis		Arthritis / Joint disease	
Low blood pressure		Tuberculosis		Gallbladder trouble		Stomach ulcers	
Chest pain / Angina		Emphysema		Fainting spells		Contagious diseases	
Heart attack(s)		Do you smoke		Convulsions / Epilepsy		Delay in healing	
Irregular heart beat		Do you use chewing tobacco		Stroke		Anemia	
Cardiac pacemaker		Blood transfusion		Thyroid trouble		Tumor or growth	
Heart surgery		Blood disorder		Diabetes		Radiation / Chemotherapy	
Bronchitis / Chronic cough		Bruise easily		A history of alcohol abuse		Are you on a diet	
Chronic fatigue / Night sweat		A history of drug abuse		Sexually transmitted diseases		Contact lenses	
Mental health problems		Eye disease / Glaucoma		Swollen ankles		Immune system problems	
Damaged heart valves		Abnormal bleeding		Malignant hyperthermia			
Are you immunosuppressed? (possibly from transplant surg.)		Problems w/ immune system? (possibly from med. / surg.)					

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

Y	N	Y	N	Y	N	Y	N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nerve pills		Pain killers (including aspirin)		Muscle relaxers		Stimulants	
Have you ever taken diet pills		Tranquilizers		Insulin		Antidepressants	
Blood thinners (Coumadin, Aspirin, Advil)		<i>Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):</i>					
Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)							

Are you allergic to or had a reaction to:

Y	N	Y	N	Y	N	Y	N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin		Sulfa drugs		Local anesthetic (numbing med)		Sodium pentothal	
Valium or other tranquilizers		Aspirin		Codeine or other narcotics		Latex	
Soy		Eggs / Yolk		Sulfites		Amoxicillin	

Please list any other medication or antibiotic you are allergic to: _____ *Please list any allergies other than drug allergies:* _____

1-4 below for women only: (women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? Yes No
2) Expected delivery date: _____
3) Are you nursing? Yes No
4) Are you taking birth control pills: Yes No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____
(Parent or Guardian if minor)

Reviewed by: _____

Date: _____

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: (Parent or Guardian if minor) _____

Date: _____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) _____

Date: _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: (Parent or Guardian if minor) _____

Date: _____