

WELCOME

1 one

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____
CITY STATE ZIP

Home Phone #: (____) _____

Work Phone #: (____) _____ Ext: _____

Cell Phone #: (____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____
CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

2 two

INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: (____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: (____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

3 three

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (____) _____

Payment method: Cash Check

_____/_____/_____
 Credit Card - Enter card # above (if accepted)

4 four

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (____) _____

Work Phone #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (____) _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials _____

PLEASE CONTINUE ON BACK 

5
five

6
six

DENTAL INFORMATION

Reason for today's visit: Exam Emergency Consultation

Are you in pain? No Yes How Long? _____

Please indicate any of the following problems:

Discomfort, clicking or popping in jaw. Lost/Broken Filling(s) Stained teeth

Red, swollen or bleeding gums. Teeth grinding Locking Jaw

Sensitive tooth, teeth or gums. Ringing in Ears Bad breath

Blisters/Sores in or around the mouth. Broken/Chipped tooth

Other: _____

Do you require pre-medication? Yes No Don't know

Previous Dentist: _____ (_____) _____
Name 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? Soft Medium Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking? Nerve pills Pain killers (including aspirin) Muscle relaxers

Stimulants Blood Thinners Tranquilizers Insulin Meds for Osteoporosis

Other(s), please list: _____

Have you ever taken: Bisphosphonates (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?

<input type="checkbox"/> Heart Attack / Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> Cosmetic Surgery
<input type="checkbox"/> Heart Surg./Pacemaker	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles	<input type="checkbox"/> Xray or Cobalt Treatment
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> HIV+/AIDS/ARC	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Arthritis/ Rheumatism	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Artificial Valves	<input type="checkbox"/> Stomach Problems/Ulcers	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Diabetes/Hypoglycemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tuberculosis TB	<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Jaw Problems TMJ/TMD	<input type="checkbox"/> Back Problems	<input type="checkbox"/> 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 Aspirin

Dental Anesthetics Foods: _____ Others: _____

Do you use tobacco? 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 Birth Control pills? Yes No How many children have you had? _____

Are you Pregnant? No 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 requires 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 understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

Adult Patient Parent or Guardian Spouse

UPDATE
(OFFICE USE)

Initials _____ Date ____/____/____

Comments _____

Initials _____ Date ____/____/____

Comments _____

Initials _____ Date ____/____/____

Comments _____