WELCOME TO OUR PRACTICE !

TODAY'S DATE: ______________

PATIENT INFORMATION

Legal Name- Last: ______________________ First: ______________ M.I. ____ M / F Marital Status: S M D W

Your nickname or name you would prefer to be called: ____________________ email address: ______________________

Address: ____

City: ______________________________ State: ______________ Zip: ______________________

Home Phone: (______) ____________________ Work Phone: (______) ____________________ ext. __________

Date of Birth: ______________________ Social Security Number: ______________________________

CHILDREN ONLY: *Parent or Guardian's Full Name:* ____

School Name: ____________________ *City, State:* ____________________ *Grade:* _____

GETTING TO KNOW YOU

Is a relative or family member a patient at our office? _____ Name: ______________________ Relationship: __________

Who may we thank for referring you to our office? ____

Your occupation / job title: ____________________________ Employer: ______________________________

Spouse's name: ______________________ Children's names / ages: __________________________________

Person to contact in case of emergency: ______________________________ Phone number: ________________

INSURANCE INFORMATION

PRIMARY INSURANCE

Employer Name: ________________________ City, State: __________________ Group Number: __________

Employee: ____________________ Relation to Patient: Self / Spouse / Child / Other Employee Date of Birth: __________

Employee Social Security Number: ____________ Employee Number: __________ Union or Local Number: __________

Insurance Company: ____

SECONDARY INSURANCE

Employer Name: ________________________ City, State: __________________ Group Number: __________

Employee: ____________________ Relation to Patient: Self / Spouse / Child / Other Employee Date of Birth: __________

Employee Social Security Number: ____________ Employee Number: __________ Union or Local Number: __________

Insurance Company: ____

PLEASE COMPLETE OTHER SIDE

ABOUT OUR OFFICE

Our office is committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment procedures.

Payment for services is due at the time services are rendered. We accept cash, checks and credit cards. We will be happy to process your insurance claim form for reimbursement. We will accept assignment of benefits on primary coverage and only when these benefits can be verified in advance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. You are ultimately responsible for all charges incurred whether or not they are covered by your dental insurance.

Our office takes your appointment time very seriously. We try as hard as possible to run 'on time' and need your help in this matter. When you appoint with the doctor or hygienist that time is reserved specifically for you. Please try to be on time or early for your appointments. As long as we receive at least twenty-four hours notice of your need to change your appointment, there will be absolutely no charge to your account. However, should we not hear from you of your need to change your appointment, there will be a $50 charge for each half-hour missed.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

______________________________ ________________

Signature Date

Relationship to patient: Self / Parent / Guardian

PLEASE COMPLETE OTHER SIDE

CONFIDENTIAL MEDICAL HISTORY

Patient Name: ______________________________ **Date:** ____________________

Medical Doctor's Name: ________________________ **Phone:** ____________________

Address: ____

Please answer the follow questions and give any pertinent details for 'yes' answers:

Are you currently under the care of a physician?	YES	NO
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	YES	NO
Are you taking any medications either prescription or over-the-counter?	YES	NO
Are you aware of any allergic or adverse reaction to any medication or substance?	YES	NO

Have you had or do you have any of the following:

Heart disease, attack or surgery	YES	NO	Cancer or tumors	YES	NO
Chest pain, angina or arteriosclerosis	YES	NO	Radiation or chemotherapy	YES	NO
Heart murmur or mitral valve prolapse	YES	NO	Drug or alcohol dependency	YES	NO
Artificial heart valve or pacemaker	YES	NO	Sinus infections	YES	NO
Rheumatic fever	YES	NO	Arthritis	YES	NO
Stroke	YES	NO	Contact lenses	YES	NO
Artificial joints (hip, knee, etc.)	YES	NO	Diabetes	YES	NO
High or low blood pressure	YES	NO	Ulcers	YES	NO
Kidney trouble	YES	NO	AIDS or HIV positive	YES	NO
Asthma, emphysema or lung disease	YES	NO	Blood transfusion	YES	NO
Tuberculosis	YES	NO	Hepatitis, jaundice, liver disease	YES	NO
Epilepsy, seizures, convulsions or fainting	YES	NO	Cortisone medication	YES	NO
Restricted diet	YES	NO	Latex Sensitivity	YES	NO
Allergies or hives	YES	NO	Venereal Disease	YES	NO
Cold sores or fever blisters	YES	NO	Bleeding problems or anemia	YES	NO
Anxiety or nervous condition	YES	NO	Any condition not listed here	YES	NO
Smoke or chew tobacco	YES	NO	**WOMEN ONLY.** Are you:		
Thyroid Problems	YES	NO	Pregnant or nursing	YES	NO
Hearing aid or cochlear implant	YES	NO	Taking birth control pills	YES	NO

I understand that the information above is used so that my dental care can be provided in a safe and effective manner. Should further information be needed, my permission is granted for you to contact my physician, hospital or health care facility and for them to release such information. Should any changes take place with regards to my health or medication, I will promptly notify you.

________________________________ ________________________

Signature Date

PLEASE COMPLETE OTHER SIDE

DENTAL HISTORY

Patient Name: ______________________________ Date: ______________

What is the main reason for your visit today? ______________________________

____

When was your last dental visit before this? __________ Last cleaning? __________ Last x-rays? __________

What was done at you last dental visit? ______________________________

Previous dentist's name: ______________________ City, State: ______________

Have you ever had a bad dental experience? YES NO If yes, please describe: ______________

How often do you usually see the dentist? ______________________________

How often do you: brush? ______________ floss? ______________

Does going to the dentist make you nervous? ______________________________

Have you ever had:

Oral surgery or extractions?	YES NO
Periodontal (gum or bone) treatment?	YES NO
Orthodontics (braces)?	YES NO
Root canal treatment?	YES NO

Do you:

Have bleeding gums?	YES NO
Clench or grind your teeth?	YES NO
Breath through your mouth or snore?	YES NO
Trap food between your teeth?	YES NO

Have you noticed:

Clicking or popping jaw?	YES NO
Pain in jaw or near ear?	YES NO
Difficulty chewing?	YES NO
Muscle or neck aches?	YES NO

Do you experience:

Mouth odors or bad taste?	YES NO
Cold sores or blisters?	YES NO
Hot / cold sensitivity?	YES NO
Sweet sensitivity?	YES NO

How do you feel about the appearance of your teeth? ______________________________

____

Would you like to keep your remaining teeth? ______________________________

Do you have any other problems that you would like the dentist to examine? YES NO ______________

____

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Do any of the following interest you:

Dental bleaching?	YES NO
Athletic mouthguard?	YES NO
Porcelain veneers?	YES NO
White fillings?	YES NO
Cosmetic bonding?	YES NO
Braces?	YES NO

PLEASE COMPLETE OTHER SIDE