WELCOME!

ABOUT YOU

Today's Date: ____________

Patient Name: ____________________
LAST FIRST MI

I prefer to be called?__________ ☐ Male ☐ Female

SS#:__________ Birth date:________ Age:____

Mailing Address:____________________

____
CITY STATE ZIPCODE

Home Phone #: ( ) ____________

Work Phone #: ( ) ________ Ext: ____

Cell Phone #: ____________

E-mail address: ____________

How did you hear about our office? ____________

Employer: ____________

How Long have you worked there? ____________

Employer's Address: ____________

____
CITY STATE ZIPCODE

Occupation:____________

Spouse's Name:____________ Date of birth________

Spouse's Employer:____________

Person responsible for account

Name:____________

Relation:____________

Billing Address: ____________

____
CITY STATE ZIPCODE

Social Security #: ____________

Drivers License #: ____________

Work Phone #: ( ) ____________

Payment method: ☐ Cash ☐ Check ☐ Credit Card

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.

Signed:____________________

INSURANCE INFO

Primary Dental Insurance

Co. Name:____________

Address: ____________

____
CITY STATE ZIPCODE

Phone #: ( ) ____________

Insured's SS or ID#:____________

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

Insured's Name: ____________

Relation: ____________ Date of Birth: ________

Insured's Employer: ____________

Secondary Dental Insurance

Co. Name: ____________

Address: ____________

____
CITY STATE ZIPCODE

Phone #: ( ) ____________

Insured's SS or ID#: ____________

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

Insured's Name: ____________

Relation: ____________ Date of Birth: ________

Insured's Employer: ____________

EMERGENCY INFORMATION

Whom should we contact?____________

Relation:____________

Home Phone #: ( ) ____________

Work Phone #: ( ) ____________

Cell Phone #: ( ) ____________

Who is your Medical Doctor?____________

Medical Doctor's Phone #: ( ) ____________

Dr's Address: ____________

Reason for today's visit : ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How Long? ____________

Please indicate ☑ if you have 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 antibiotics before dental treatment? ☐ **Yes** ☐ **No** ☐ **Don't know**

Previous Dentist: ____________ ( ) ____________

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

Do you use an electric toothbrush? ______ If so, what kind? ________

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

UPDATES

Initials Date

Health/Medication Changes

Initials Date

Health/Medication Changes

Initials Date

Health/Medication Changes

Initials Date

Health/Medication Changes

Are you taking any of the following medications? Anti-anxiety or Anti-depressant ________ Insulin ________

Pain killers (including aspirin) ________ Muscle relaxers ________ Blood Thinners ________

Tranquilizers ________ High Blood Pressure ________ Other(s), please list: ________

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

Y N Heart Attack/Stroke	Y N Diabetes/Hypoglycemia	Y N Kidney Problems	Y N Hepatitis
Y N Heart Surgery/Pacemaker	Y N Chest Pains	Y N Liver Problems	Y N HIV+/AIDS/ARC
Y N Heart Murmur	Y N Asthma (active:bring inhaler)	Y N Stomach Problems/Ulcers	Y N Chemotherapy
Y N Rheumatic or Scarlet Fever	Y N Respiratory Problems	Y N Severe/Frequent Headaches	Y N Shingles
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Frequent Neck Pain	Y N Nervousness
Y N Artificial Valves	Y N Difficulty Breathing	Y N Jaw Problems TMJ/TMD	Y N Glaucoma
Y N Heart Disease	Y N Emphysema	Y N Back Problems	Y N Psychiatric Problems
Y N Congenital Heart Defect	Y N Fainting/Seizures/Epilepsy	Y N Thyroid Problems	Y N Alcohol/Drug Abuse
Y N High/Low Blood Pressure	Y N Tuberculosis **TB**	Y N Arthritis/Rheumatism	Y N Cancer/Tumors
Y N Bleeding Problems	Y N Anemia	Y N Venereal Disease	Y N X-ray or Cobalt Treatment
Y N Artificial Bones/Joints	Y N Leukemia		

Please list any other surgeries or medical conditions you have or ever had: ____________

Are you allergic to any of the following medications? ☐ Penicillin/Amoxicillin ☐ Erythromycin ☐ Aspirin ☐ Codeine ☐ Tetracycline ☐ Dental Anesthetics ☐ Others: ____________

Do you use tobacco? ☐ No ☐ Yes/How used? ________ How much? ________ How Long? ________

Rate your general health from 1-10 (10 being best): ________

For Women: Are you taking Birth Control pills? ☐ Yes ☐ No

Are you pregnant? ☐ No ☐ Yes/How far along? ________ 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 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 or prepare referrals to another provider of services..
- 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.
- **In consideration of our employees and other patients, we ask that you refrain from wearing any type of fragrances to your appointments.**

Signature: ____________ Date / /

☐ Adult Pa t ☐ Parent or Guardian ☐ Spouse