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 _____ Apt. _____ City _____ State _____ Zip _____

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

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) 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...

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

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

INSURANCE INFORMATION...

Student: ❑ Full Time ❑ Part Time ❑ Not School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

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

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(_____) _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(_____) _____

DENTAL INFORMATION...

Reason for today's visit _____ Are you in pain? ❑ Yes ❑ No, For How Long? _____

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

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

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

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

MEDICAL HISTORY...

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

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

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

Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ 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	
❑	❑	Rheumatic fever	❑	❑	Are you immunosuppressed *(possibly from transplant surg.)*	❑	❑	Bleeding tendency	❑	❑	Kidney trouble
❑	❑	Mitral valve prolapse				❑	❑	Problems w/ immune system *(possibly from med. / surg.)*	❑	❑	Are you on dialysis
❑	❑	Heart murmur	❑	❑	Hay fever / Sinus problems				❑	❑	Arthritis / Joint disease
❑	❑	High blood pressure	❑	❑	Snoring / Sleep apnea	❑	❑	Jaundice / Liver disease	❑	❑	Prosthetic joint / Implant
❑	❑	Low blood pressure	❑	❑	Respiratory problems	❑	❑	Hepatitis	❑	❑	Osteoporosis / Osteopenia
❑	❑	Chest pain / Angina	❑	❑	Tuberculosis	❑	❑	Infectious mononucleosis	❑	❑	Osteonecrosis
❑	❑	Heart attack(s)	❑	❑	Emphysema	❑	❑	Gallbladder trouble	❑	❑	Stomach ulcers
❑	❑	Irregular heart beat	❑	❑	Do you smoke	❑	❑	Fainting spells	❑	❑	Contagious diseases
❑	❑	Cardiac pacemaker			*if so, # packs a day*_____	❑	❑	Convulsions / Epilepsy	❑	❑	Delay in healing
❑	❑	Heart surgery	❑	❑	Do you use chewing tobacco	❑	❑	Stroke	❑	❑	Anemia
❑	❑	Pneumonia / Bronchitis / Chronic cough	❑	❑	Blood transfusion	❑	❑	Thyroid trouble	❑	❑	Tumor or growth
❑	❑	Chronic fatigue / Night sweat	❑	❑	Blood disorder	❑	❑	Diabetes	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	Bruise easily	❑	❑	A history of alcohol abuse	❑	❑	Are you on a diet
❑	❑	Mental health problems	❑	❑	A history of drug abuse	❑	❑	Sexually transmitted diseases	❑	❑	Contact lenses
❑	❑	Damaged heart valves	❑	❑	Eye disease / Glaucoma	❑	❑	Swollen ankles			
❑	❑	Asthma	❑	❑	Abnormal bleeding	❑	❑	Low blood sugar			

MEDICATION & ALLERGIES...

Are you now taking, or have you ever taken:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	Blood thinners (Coumadin, Aspirin, Advil)									
❑	❑	Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)									

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION			DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	I have no known allergies.

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.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

FEES & 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.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **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.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)*

X _____ **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.

X _____ **Signature of patient** *(Parent or Guardian if minor)*

X _____ **Date**