PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

(Please Print)

Today's Date _____

Patient Name _____ Birthdate _____ Age _____
FIRST MI LAST

What You Prefer to be Called _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Occupation _____

Spouse or Parent/Guardian Name (if minor) _____

Patient or Parent/Guardian Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

If Patient is Student, Name of School/College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact In Case of Emergency _____ Phone _____ Relation _____

RESPONSIBLE PARTY / ACCOUNT INFORMATION

Name of Person Responsible for this Account _____ Relation _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Driver's License # _____ Birthdate _____ SS # _____

Employer _____ Work Phone _____

Is This Person Currently A Patient In Our Office? ☐ Yes ☐ No

Payment Method ☐ Cash ☐ Check ☐ Credit Card# _____ ____/____
Enter card # and expiration date above (if accepted)

_____ 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

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company Name _____ Phone # _____

Ins Co Address _____ City _____ State _____ Zip _____

Group # (Plan, Local or Policy #) _____ Insured's ID# _____

Name of Insured _____ Relation _____

Birthdate _____ SS # _____ Date Employed _____

Name of Employer _____ Work Phone _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit? _____

Secondary Dental Insurance (if applicable)

Insurance Company Name _____ Phone # _____

Ins Co Address _____ City _____ State _____ Zip _____

Group # (Plan, Local or Policy #) _____ Insured's ID# _____

Name of Insured _____ Relation _____

Birthdate _____ SS # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Continue on Back

PATIENT MEDICAL HISTORY

Physician _____ Office Phone # _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol?	☐	☐
6. Do you use cocaine or methamphetamine? *(reacts with anesthesia)*	☐	☐
7. Are you taking a daily aspirin or baby aspirin?	☐	☐
8. Are you currently or have you taken medication for bone issues?	☐	☐

9. Are you allergic to or have you had any reactions to the following?

	Yes	No		Yes	No	Other
Local Anesthetics (eg. Novocaine)	☐	☐	Penicillin or other Antibiotics	☐	☐	_____
Barbiturates	☐	☐	Sedatives	☐	☐	_____
Sulfa Drugs	☐	☐	Iodine	☐	☐	_____
Latex	☐	☐	Aspirin	☐	☐	_____

	Yes	No
10. Do you have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)?	☐	☐
11. Are you wearing contact lenses?	☐	☐
12. Women Only:		
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking birth control pills?	☐	☐

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

	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Hepatitis / Jaundice	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Cardiac Pacemaker	☐	☐	Sexually Trans. Disease	☐	☐	Radiation Therapy	☐	☐
Heart Attack	☐	☐	Heart Murmur	☐	☐	Stomach Issues / Ulcers	☐	☐	Glaucoma	☐	☐
Rheumatic Fever	☐	☐	Angina / Chest Pains	☐	☐	Heart Trouble	☐	☐	Liver Disease	☐	☐
Fainting / Seizures	☐	☐	Anemia	☐	☐	Stroke	☐	☐	Frequently Tired	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer / Tumors	☐	☐	Asthma	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Respiratory Problems	☐	☐	Other		
Diabetes	☐	☐	Joint Replacement / Joint Implant	☐	☐	Emphysema	☐	☐	_____		
Kidney Diseases	☐	☐				Sinus Issues / Allergies	☐	☐			
Thyroid Problem	☐	☐	AIDS or HIV Infection	☐	☐	Easily Winded	☐	☐	_____		

PATIENT DENTAL HISTORY

1. What was the date of your last dental exam? _____

	Yes	No
2. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
4. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
5. Do you feel pain to any of your teeth?	☐	☐
6. Do you have any sores or lumps in or near your mouth?	☐	☐
7. Have you had any head, neck or jaw injuries?	☐	☐
8. Have you ever experienced any of the following problems in your jaw? a. Clicking?	☐	☐
b. Pain (joint, ear, side of face)?	☐	☐
c. Difficulty in opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐

	Yes	No
9. Do you have frequent headaches?	☐	☐
10. Do you clench or grind your teeth?	☐	☐
11. Do you bite your lips or cheeks frequently?	☐	☐
12. Have you ever had any difficult extractions in the past?	☐	☐
13. Have you had any orthodontic work?	☐	☐
14. Have you ever had prolonged bleeding following extractions?	☐	☐
15. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
16. Have you ever had instructions on the care of your gums?	☐	☐

SIGNATURE

- 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 office manager. If account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for finance charges, legal fees, collection agency fees and any other expenses incurred in collecting your account. Our policy includes a $25 return check fee.
- I understand the office's Reservation Fee policy, if I miss an appointment without a 24-hour notice, I may be charged a fee for my next appointment.
- 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 provided.

X _____ _____

Patient Signature (Parent or Guardian) Date