Welcome

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Soc. Sec. # ____________

Date ____________

Email ____________

Patient Information (CONFIDENTIAL)

Cell Phone ____________

Name ____________ ❑ Male ❑ Female Birthdate ____________ Home Phone ____________

Address ____________ City ____________ State ____ Zip ____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name of School / College ____________ City ____________ State ❑ Full Time ❑ Part Time

Patient's or Parent's Employer ____________ Work Phone ____________

Business Address ____________ City ____________ State ____ Zip ____

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

Spouse Birthdate ____________ SS# ____________

Whom May We Thank for Referring You? ____________

Nearest Relative not Living with You ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________

Address ____________ Home Phone ____________

Driver's License # ____________ Birthdate ____________ Financial Institution ____________

Employer ____________ Work phone ____________ SSN# ____________

Insurance Information

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Name of Employer ____________ Work Phone ____________

Address of Employer ____________ City ____________ State ____ Zip ____

Insurance Company ____________ Group # ____________ Policy/ID# ____________

Ins. Co. Address ____________ City ____________ State ____ Zip ____

How Much is your Deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❑ Yes ❑ No *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Address of Employer ____________ City ____________ State ____ Zip ____

Insurance Company ____________ Group # ____________ Policy/ID# ____________

Ins. Co. Address ____________ City ____________ State ____ Zip ____

How Much is your deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

Over Please

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 within the last 5 years? If yes, please explain ______________	❑	❑
3. Are you taking any medication (s) including non-prescription medicine? If yes, Please List any you are taking. ______________	❑	❑
4. Do you use tobacco?	❑	❑
5. Do you use controlled substances?	❑	❑

Has Your Physician told you to take Antibiotics before dental care? ❑ Yes ❑ No

	Yes	No
7. Are you taking any Herbal Supplements ______	❑	❑
8. Are you allergic to or have you had any reactions to the following?		
Codeine	❑	❑
Local Anesthetics	❑	❑
Penicillin (or other Antibiotics)	❑	❑
Sulfa Drugs	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list) ______________	❑	❑
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you taking oral contraceptives?	❑	❑
10. Are you taking medication for osteoporosis?	❑	❑
11. Are you taking coumadin?	❑	❑

6. Do you or have you experienced any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease/Attack	❑	❑	Allergies	❑	❑	Prolonged Bleeding	❑	❑
High Blood Pressure	❑	❑	Diabetes	❑	❑	Cold Sores/Fever Blisters	❑	❑
Rheumatic Fever	❑	❑	Kidney Diseases	❑	❑	Cancer	❑	❑
Heart Murmur	❑	❑	AIDS Infection	❑	❑	Glaucoma	❑	❑
Heart Surgery	❑	❑	HIV Infection	❑	❑	Hepatitis A,B,C	❑	❑
Mitral Valve Prolapse	❑	❑	Sexually Transmitted Disease	❑	❑	Jaundice	❑	❑
Heart Valve Replacement	❑	❑	Emphysema	❑	❑	Arthritis	❑	❑
Stroke	❑	❑	Tuberculosis (TB)	❑	❑	Joint Replacement	❑	❑
Fainting	❑	❑	Radiation/Cobalt Treatment	❑	❑	Implant	❑	❑
Seizures/Epilepsy	❑	❑	Thyroid Problem	❑	❑	Bisphosphonates	❑	❑
Asthma	❑	❑				Other	❑	❑

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________

1. Date of Last full mouth X-ray or Panoramic X-Ray ________

	Yes	No
2. Do your gums bleed while brushing or flossing?	❑	❑
3. Are your teeth sensitive?	❑	❑
4. When was the last time you had your teeth professionally cleaned? ______________		
5. Why are you changing dentists? ______________		
6. Do you feel pain with any of your teeth?	❑	❑
7. Do you have any sores or lumps in or near your mouth?	❑	❑
8. Have you had any head, neck or jaw injuries?	❑	❑
9. Have you ever experienced any of the following problems in your jaw?		
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in chewing	❑	❑

	Yes	No
10. Do you clench or grind your teeth?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding following extractions?	❑	❑
13. Have you had any orthodontic treatment?	❑	❑
14. Do you wear dentures or partials? If yes, date of placement	❑	❑
15. Are you interested in whitening your teeth?	❑	❑
16. Would you like to discuss how we could improve your smile?	❑	❑
17. Would you like to discuss what cosmetic dentistry could do for you?	❑	❑

1. I affirm that the information given today is correct. I understand that it is my responsibility to inform this office of any changes in my medical history. ______________________
2. All accounts are due and payable as treatment progresses, regardless of insurance coverage. The portion of our fee which is not covered by your insurance company is due at the time of each visit.
3. Please be certain to bring at least one insurance form for each appt. We will be happy to submit your forms to your insurance company for payment; however, the responsibility for payment ultimately lies with you the patient. Within 60 days of filing, payment is expected by either you or your insurance company.
4. After 90 days, a billing charge of 1.5% of the unpaid balance will be added to the account monthly.

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO DENTAL CLAIMS. ______________

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST
FOR INSURANCE BENEFITS OTHERWISE PAYABLE TO ME: ______________________