About You

Today's Date: _____

Patient Name: _____

First MI Last

What You Prefer To Be Called: _____ □ Male □ Female

Birthdate: _____/_____/_____ Age:____ SS#:_____

Mailing Address: _____

_____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Email Address:_____

How would you prefer to be contacted in regards to your appointments?

□ Home phone □ Work phone □ Cell phone □ E-mail

Employer:_____

Employer's Address: _____

_____

Occupation: _____

Status: □ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse's Name: _____

Do you have children? □ Yes □ No How Many? _____

Insurance Info

Primary Dental Insurance

Co. Name: _____

Address: _____

_____

Phone#: (_____) _____

Insured's ID#:_____

Group #: _____

Insured's Name: _____

Relation: _____Date of Birth:___/__/__

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____

Phone#: (_____) _____

Insured's ID#:_____

Group #: _____

Insured's Name: _____

Relation: _____Date of Birth:___/__/__

Insured's Employer: _____

Account Info

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

SS #: _____

Driver's License #: _____

Work Phone #: (_____) _____

Payment method □ Cash □ Check □ Credit Card

If you would like us to we can keep a credit card on file for you.

#_____ EXP: ___/__ CVV#: _____

I hereby authorize assignment of my insurance rights and benefits 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

In Case of Emergency

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

Referral

How did you hear about our office?

_____

For all Yes answers, please give a brief explanation:

1. Have you ever been hospitalized or had a major operation? ☐ No ☐ Yes, _____

_____

2. Have you ever had a serious head or neck injury? ☐ No ☐ Yes, _____

_____

3. Please list any medications, pills or drugs and the conditions in which you take them for:

_____

_____

_____

4. Do you take, or have you taken Phen-Fen or Redux? ☐ No ☐ Yes, _____

5. Have you taken any pills, IV treatment or injections for the treatment of osteoporosis?

(ex: Aredia, Fosamax, Prolia, Boniva, Actonel, Reclast, etc.) ☐ No ☐ Yes, _____

6. Are you currently taking any blood thinner medications?

(ex: Aspirin, Coumadin, Plavix, Effient, Pradaxa, Eliquis, Xarelto, etc) ☐ No ☐ Yes, _____

7. Have you had Head/Neck Radiation Treatments? ☐ No ☐ Yes, _____

8. Are you on a special diet? ☐ No ☐ Yes, _____

9. Do you use tobacco (smoke, smokeless or vapor-cigarette)? ☐ No ☐ Yes, _____

10. Do you use controlled substances? ☐ No ☐ Yes, _____

11. Women: Are you ☐ Pregnant? ☐ Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

12. Allergies? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Milk

☐ Other, please list:_____

Dental History

Name of Previous Dentist:_____

City, State: _____ Phone #:_____

Why did you leave your previous dentist? _____

_____

When was your last cleaning? _____

When were your last X-rays? _____

Do you have any current dental concerns?_____

_____

What is most important to you about your dental visit today? _____

_____

How important is dental health to you?

Not important - 0 1 2 3 4 5 - Very important

How do you rate your current dental health?

Not good - 0 1 2 3 4 5 - Very good

Do you have, or have you had, any of the following?

Heart/Blood

☐ Anemia
☐ Angina
☐ Artificial Heart Valve Year:____
☐ Blood Disease
☐ Blood Transfusion
☐ Congenitial Heart Disorder
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heartbeat
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Sickle Cell Disease
☐ Other Heart/Blood Condition

Brain/Nervous

☐ Convulsions
☐ Epilepsy or Seizures
☐ Fainting/Dizzy Spells
☐ Stroke
☐ Other Brain/Nervous Condition

Endocrine

☐ Diabetes HbA1c:____
☐ Hypoglycemia
☐ Parathyroid Disease
☐ Thyroid Disease
☐ Other Endocrine Condition

Lung/Respiratory

☐ Asthma
☐ COPD/Emphysema
☐ Hay Fever
☐ Other Lung/Breathing Condition

Digestive

☐ Colitis
☐ Stomach/Intestinal Disease
☐ Ulcers
☐ Other Digestive Condition

Bone/Joints

☐ Arthitis/Gout
☐ Artificial Joint Year:____
☐ Osteomyelitis
☐ Osteoporosis
☐ Rheumatism
☐ Other Bone/Joint Condition

Conditions/Diseases

☐ AIDS/HIV Positive
☐ Anaphylaxis
☐ Cancer Type:_____
☐ Cold Sores/Fever Blisters
☐ Cystic Fibrosis
☐ Drug Addiction
☐ Glaucoma
☐ Hives/Rash
☐ Leukemia
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shingles
☐ Sinus issues/surgery
☐ Spina Bifida
☐ Tonsilitis
☐ Tuberculosis
☐ Tumors/Growths

Treatments

☐ Chemotherapy Year:____
☐ Cortisone Medicine
☐ Radiation Treatments
To what region? _____

Behavioral/Emotional

☐ Psychiatric Care
☐ ADD/ADHD
☐ Alzheimer's Disease
☐ Autism
☐ Other Behavioral/Emotional Condition

Liver/Kidney

☐ Hepatitis A, B or C (circle type)
☐ Renal Dialysis
☐ Yellow Jaundice
☐ Other Liver/Kidney Condition

Have you noticed

☐ Bruising Easily?
☐ Chest Pains?
☐ Easily Winded?
☐ Excessive Bleeding?
☐ Excessive Thirst?
☐ Frequent Cough?
☐ Frequent Headaches?
☐ Pain in Jaw Joints?
☐ Recent Weight Loss?
☐ Swelling of Limbs?

Please list any conditions that you have that are not listed above:

- **We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understand 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 financial coordinator. 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 and collection agency fees, interest charges and any other expenses incurred in collection on 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.**
- **I understand that above information and guarantee this form was completed correctly to the best of my knowledge and I understand that providing incorrect information can be dangerous to my (or patient's health). I understand it is my responsibility to inform this office of any changes to the information I have provided.**

Patient Signature **Date**

Dentist Signature **Date**