Welcome

ABOUT YOU

Today's Date: ____________________ E-mail Address: ____

Name: ____ I prefer to be called: _____________________ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: ______ Social Security #: ____________________________ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: ____
Street City State Zip

Home Phone #: (_____)__________ Cell #: (_____)__________ Work Phone #: (_____)__________ Ext: ____ Driver License #: ______________

Where & when are best times to reach you? ____________________ Whom may we Thank for referring you? ______________________________

Other family members seen by us: ____

Employer: ____ How long there? ______________ Occupation: __________________________

Employer's Address: ____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: __________________________ Relation: ____________ Work Phone #: (_____)__________ Home Phone #: (_____)__________

Address: ____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _________________________ Relation: ______________ Home Phone #: (_____)__________ Social Security #: _______________

Employer: ____________________________ Work Phone #: (_____)__________ Ext: ___ Drivers License #: ______________________

Billing Address: ____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: ____ Birthdate: ___/___/___ Social Security #: ______________________

Employer: ____ Work Phone #: (_____)__________ Ext: _____ Drivers License #: __________

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ___________________________ Phone #: (_____)__________ Group # (Plan, Local or Policy #): ______________

Insurance Co. Address: ____
Street/PO Box City State Zip

Insured's Name: _________________________ Insured's Social Security #: ______________ Insured's Birthdate: ___/___/___ Relation: ________

Insured's Employer: ______________________ Employer's Address: ____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ___________________________ Phone #: (_____)__________ Group # (Plan, Local or Policy #): ______________

Insurance Co. Address: ____
Street/PO Box City State Zip

Insured's Name: _________________________ Insured's Social Security #: ______________ Insured's Birthdate: ___/___/___ Relation: ________

Insured's Employer: ______________________ Employer's Address: ____
Street/PO Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? ____________________

____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? ____________________

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? ____________________

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ____________________

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? ____________________

Previous / Present Dentist: ____________________ Last Visit Date: ________
(Please Circle)

Why did you leave your previous dentist? ____________________

What did you like most & least about any dentist you have seen? ____________________

____

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? ____________________

____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No Date of last visit: ________

Physician's Name: ____________________

Address: ____________________ Phone #: (___)________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ____________________

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ Yes ❑ No

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry / Metals
Y N Latex
Y N Penicillin
Y N Sedatives
Y N Sulfa Drugs
Y N Tetracycline
Y N Other

Please list additional drugs/materials that cause allergic reactions: ____________________

____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: ________ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen
Y N Antibiotics
Y N Antihistamines
Y N Aspirin
Y N Blood Thinners
Y N Blood Pressure Medication
Y N Cold Remedies
Y N Digitalis/Heart Medication
Y N Insulin/Diabetes Drugs
Y N Nitroglycerin
Y N Recreational Drugs
Y N Steroids/Cortisone
Y N Thyroid Medicine
Y N Tranquilizers

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ❑ Yes ❑ No If yes, please list each one: ________

____

Do you or have you experienced the following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma
Y N Hay Fever
Y N Headaches
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis/Paget's Disease
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Treatment
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: ____________________

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be ____________________.

____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by ____________________ Insurance Co. and I assign directly to Dr. ____________________ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____
Signature Date

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Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of $65 for all missed appointments("no shows") and appointment which, absent a compelling reason, are not cancelled with a 24-hour advance notice. THIS FEE IS NOT COVERED BY INSURANCE AND MUST BE PAID BY YOUR NEXT APPOINTMENT.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

______________________________ ______________________________

Print name **Date**

____

Signature