

WELCOME!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible.

If you have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name _____ (If child, parent/guardian name) _____
Last name First name Initial

Birthdate _____ Sex _____ Age _____ Soc. Sec. # _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell phone _____

E-Mail _____ Drivers License # _____

How did you hear about our practice? _____

Employer _____ Occupation _____ How long there? _____ May we call? _____

Employer Address _____ City _____ State _____ Zip _____

Spouse's Name (Or other parent/guardian) _____ Soc. Sec. # _____

Spouse's Employer _____ Occupation _____ How long there? _____ May we call? _____

Spouse's Employer Address _____ City _____ State _____ Zip _____

If patient is a student: Name of school/college: _____ City & State _____ Full time or part time? _____

Primary Insurance:

Name of Insured _____

Birthdate _____ Relationship to patient _____

Address (if different from patient) _____

Dental Insurance Co. _____ Phone _____

Social Security # _____ Subscriber ID # _____

Group, Contract or Local or union # _____

Additional Insurance:

Name of Insured _____

Birthdate _____ Relationship to patient _____

Address (if different from patient) _____

Dental Insurance Co. _____ Phone _____

Social Security # _____ Subscriber ID # _____

Group, Contract or Local or union # _____

Copayments:

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check:

CIRCLE ONE: Visa MasterCard Discover Amex

Account# _____ Expiration date _____ Name on card _____

CVW# _____ Credit Card Debit Card ATM Voided check attached.

In Case of Emergency:

Name and City of primary care physician _____

Someone we may contact, not living with you: _____ Phone #'s (home, work, cell) _____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I further authorize this office to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

Patient or Responsible Party

Dental History

Patient Name _____ Age _____ Date _____

Reason for seeking care today: ___ Exam ___ Cleaning ___ Specific Problem _____

Please check all that apply:

(Please describe)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Bite or teeth have shifted | <input type="checkbox"/> Cracked, chapped lips | <input type="checkbox"/> Unable to open mouth wide |
| <input type="checkbox"/> Broken filling or tooth | <input type="checkbox"/> Often bite cheeks | <input type="checkbox"/> Bad taste in mouth | <input type="checkbox"/> Jaw gets tired easily. |
| Sensitivity to: | <input type="checkbox"/> Frequent dry mouth | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Hold things between teeth
(Pipe, pencil, nails, pins) |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Concerned about breath | <input type="checkbox"/> Mouth breathe - Difficulty
breathing through nose | <input type="checkbox"/> Bite fingernails |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Unhappy with previous
dental work | <input type="checkbox"/> Dry or strained eyes | <input type="checkbox"/> Unusual habits with teeth |
| <input type="checkbox"/> Sweets | <input type="checkbox"/> Gums bleed | <input type="checkbox"/> Shoulder, neck or headaches | <input type="checkbox"/> Wore braces |
| <input type="checkbox"/> Chewing | <input type="checkbox"/> Gums tender | <input type="checkbox"/> Clench or grind teeth | <input type="checkbox"/> Previous gum treatment |
| <input type="checkbox"/> Food catches | <input type="checkbox"/> Growths, sores | <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Previous bite treatment |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Cold sores, fever blisters | <input type="checkbox"/> Clicking or popping of joint. | |
| <input type="checkbox"/> Floss breaks easily or hurts | | | |

Would you like whiter teeth? _____ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile? _____

Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

Why did you leave your previous dentist? _____

Did your parents have difficulties with their teeth or dental treatments? _____

Medical History

Physicians Name: _____

City: _____ Phone _____

Have you been hospitalized for any reason? Please describe: _____

Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed) _____

Are you taking or have ever taken Bisphosphonates? If yes, name of drug and how long taken. _____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, jewelry, metal, tetrocycline, food allergies, other? _____

Do you smoke? How much/day? _____

Pregnant? Due date _____ Are you nursing? _____

Are you seeing a physician now or planning to see one for any reason? _____

Please explain: (Continue on back of form if needed) _____

Please check all that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Previous injury to head or neck | <input type="checkbox"/> Depression | <input type="checkbox"/> Psychotic problems | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Heart problem | <input type="checkbox"/> T8 | <input type="checkbox"/> STD | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive problem, ulcer | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Angina, chest pain | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Snoring, sleep apnea |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney problem | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> No energy |
| <input type="checkbox"/> Scarlet, Rheumatic fever | <input type="checkbox"/> Liver problem, jaundice | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Fainting or dizzy |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Cirrhosis, Hepatitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Cancer, Radiation, Chemotherapy | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Chewing tobacco |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Respiratory problem | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Drug or alcohol addiction |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Bloody, persistent cough | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> 2 or more social drinks/day |
| <input type="checkbox"/> Artificial joint, bones, valves | <input type="checkbox"/> Asthma, Emphysema | <input type="checkbox"/> Back problem | <input type="checkbox"/> Anxiety or nervous disorder |
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hives, rash | <input type="checkbox"/> Insomnia |
| | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Contact lenses |
| | <input type="checkbox"/> Osteoporosis (list meds) | <input type="checkbox"/> Colitis | <input type="checkbox"/> Herpes/Fever Blisters |

Any other illnesses not checked above? _____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: Yes No

Please rate the following indicators of your daily stress level: 1-10 : (1 = low, 10 = high)

____ Overworked, too busy, pressured ____ Feel frustrated ____ Get upset or "snap" easily ____ Depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian) _____ Date _____

Dentist' Signature _____ Date _____